PLANNING COMPREHENSIVE MENTAL HEALTH SERVICES IN COLORADO

Volume II:

EXPLORING THE BOUNDARIES OF MENTAL HEALTH

THE REPORTS OF NINE SPECIAL TASK FORCES

TO

THE STATE MENTAL HEALTH PLANNING COMMITTEE

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Apr22'68	Marbella Smith Costilla County
Nov27'68	Charles Doman
Oct30'70	Marilyn Neilart
Apr12'71	Susan Ziegler
Dec1'72	Mary Alice Hammerly Denver
Feb21'73	Susan Witt
GAYLORD 45	

PLANNING COMPREHENSIVE MENTAL HEALTH SERVICES IN COLORADO

Volume II:

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The first volume of this report on comprehensive mental health planning was largely the result of lay citizens, working with some of the professionals in their communities, examining some fundamental issues which involve community needs and community solutions in mental health. In contrast, this second volume is almost entirely the product of professionals in the fields of mental health, welfare, public health, education, corrections and rehabilitation. The issues discussed should eventually become the active concern of all citizens, just as those which directly concern communities are already the concern of all citizens. But the problems in this volume are first of all technical in nature -- and advance exploration by the professionals themselves seemed warranted.

These problems are also state-wide in nature: they involve such matters as the supply of mental health professionals, the economics of mental illness, legislation involving the rights of the mentally ill. And some can only be solved on a state level, such as uniform data collection systems, state policy on research and program evaluation, etc.

On behalf of the Governor of Colorado and the Department of Institutions, I wish to personally thank the one-hundred and eight persons who served on the nine groups which produced this volume of reports.

David A. Hamil, Director
Department of Insitutions

INTRODUCTION: A Handy Guide For Exploring This Volumn

Mental health has frequently been described as a "nucleus without any very obvious boundaries." This statement puzzles the layman more than the inside professional -- but it embraces one of the central issues of mental health planning and it is sufficiently important that everyone, lay or professional, citizen or legislator, may find himself having to ponder its implications as mental health programs continue to develop in the future.

The problem is this: irrational behavior plays a role -- is one of the "causes" helping to produce -- an enormous number of human problems. It is a factor in most divorces, in job absenteeism, in joy riding and drag racing, in over-eating and alcoholism, in racial discrimination, in attitudes toward the aged, even in traffic control or problems of urban renewal. It is a factor in these problems but it is not the only factor. Nor would anyone reasonably suppose a mental health program should have prime responsibility for solving most of these problems.

But what should be the responsibility of mental health toward such closely tangential problems? In the early days of the mental hygiene movement, it was easy for a pilot clinic to handle a few delinquent children, to experiment with counseling for some divorce problems referred by a local judge, to try out psychotherapy with an occasional alcoholic. But if a mental health service graduates from the "pilot-demonstration" phase and becomes a recognized basic public service, what are its precise responsibilities? How "comprehensive" should the services of a comprehensive mental health center be?

It should be added that the problem was neatly solved in the old days by the isolated custodial hospital. The old-time state hospital took in practically any kind of case sent to it, regardless of diagnosis or whether the "patient" was really a psychiatrically disturbed person or some other kind of misfit. Almost any kind of community deviant or troublemaker could -- and many did -- end up in the old kind of state hospital as "insane". Such hospitals became dumping grounds for unsolved community problems. They were soon properly labelled by a very technical term -- the bughouse. And no one expected them to do much treatment or send many inmates back to the community.

To the members of Colorado's State Mental Health Planning Committee, it was clear that a modern mental health program would have to be held accountable for handling major emotional disorders in adults and children.

But in preventing even these disorders, it would often find itself sharing responsibility with such allied resources as the family physician, the public health department, or public welfare. It was also clear that in a number of areas, human disorders existed with mental health implications but no clear degree of responsibility for mental health professionals. Specifically, four major types of "socially defined" disorders were noted:

Delinquency
Adult Criminal Behavior
"Dependency" (welfare, etc.)
Alcoholism and Addiction

In addition, three groups of disorders usually held to be primarily biological in nature but with obvious mental health implications were noted:

Mental retardation
Aging Syndromes
Physical Illness

Even this attempt to categorize problems ran into obvious overlap. It could be argued that alcoholism involves biologic addiction as well as behavior socially defined as deviant. And it may result in biologic death. Similarly, mental retardation -- at least that part stemming from "cultural deprivation" -- can involve social problems as important to causality as genetics or brain damage. And is the psychosomatic ulcer primarily a biologic problem or a psychologic stress problem?

It was obvious that many of these demarcations would never be resolved during this initial planning effort. It was also obvious that available staff time as well as professional interest should dictate some priorities. Accordingly, in the present volume you will find three sets of reports on disorders with major mental health implications:

1) Emotionally Disturbed Children
2) Juvenile Delinquency
3) Alcoholism and Addiction

Each report is the product of many months work by a group of professionals. Each concerns problems in which mental health services should play a role but in which allied agencies and other kinds of professionals also have major roles to play. Incidentally, the task force on Emotionally Disturbed Children was set up because here is a group of disorders which -- although at first glance the primary responsibility of mental health programming -- actually involves a host of allied agencies at almost every step. Especially if true prevention is to ever become a reality capable of being systematically evaluated and improved on the basis of scientific scrutiny, allied agencies will undoubtedly play a role as fundamental as that of most formal mental health services. This task force, then, included public health officers and public health nurses, child welfare workers, pediatricians, youth rehabilitation experts, etc.

Besides seeking logical boundaries, a record theme repeatedly emerged -- and was underscored in the second set of task force reports -- the imperative need for better data systems in this state.

A repeated frustration was the lack of really sophisticated bodies of information upon which to base judgments. Rates of juvenile delinquency, for instance, are impossible to obtain on any sort of valid and comparative basis for the various counties. So striking was this dearth that the delinquency task force devoted much ot its energy to setting up a new data form -- adapted for electronic processing -- for the use of District Courts throughout the state as well as state services for adjudicated delinquents. Similarly, the alcoholism task force wondered about the continued guesswork on the number of alcoholics in Colorado (present estimates are based upon the "Jellinek formula", the best available but repudiated by Jellinek himself shortly before his death!). It asked for some pilot studies in incidence and prevalence.

Again and again the need for better research support comes out, better data systems, more attention to acquiring valid knowledge so that program evaluation may someday replace guesswork. This situation is particularly frustrating to the professionals in the field for two reasons: first, the hardware is now available! Computer technology is far ahead of any of the wildest dreams of researchers a few years ago. Ongoing continuous systems of evaluation are now feasible which would have required an army of clerks but a decade ago.

The second frustration is the lack of public understanding of the need for -- and the new practicality of -- research and program evaluation. Underscored in the reports on economics, manpower, research, and case registers is the belief that while the average citizen is now ready to support treatment services, he has almost no enthusiasm for using state funds for evaluating these treatment efforts. Federal research grants are all very well for the special research project, the three year investigation of some promising lead into a facet of schizophrenia or genetic endowment. But ongoing evaluation of a program which costs the state nearly $40,000,000 a year in direct and indirect costs would seem a practical and prudent thing to do -- and with at least some commitment through state funds.

But predictions were flatly made that the recommendation of a state "research council" to be appointed by the Governor, and the establishment of at least skeleton staffs to engage in basic program evaluation, would be the most easily overlooked of all the recommendations in this volume. Time will tell!

We offer, then, these task force reports for what they are: initial, sometimes fumbling efforts to come to grips with some abiding issues in mental health. Some areas were not even explored -- and future planning will have to open up such questions as the ideal mental health role for problems

of the aged or chronic dependency cases or adult criminals. Other tasks were begun but with a feeling that efforts should continue. An ongoing group to further explore alcoholism and addiction problems was urged. The architecture task force asked that it be enlarged and kept in being. The multi-agency group in children felt its work should be permamently sponsored by the Department of Institutions. And of course, the task force on legislation made only a beginning by revising the law on short-term hold and treat commitments. Future mental health legislation will require still closer working bonds between those once distant disciplines, psychiatry and the law!

Stanley W. Boucher, A.C.S.W.
Assistant Director
Mental Health Planning Project

TASK FORCE ON THE NEEDS

OF EMOTIONALLY DISTURBED CHILDREN: Summary of Recommendations

The total recommendations made by this thirty-member group of professionals are so detailed as to make a capsule summary difficult indeed. Hopefully, the major highlights appear below. It will be noted that most relate to goals and treatment techniques--the qualitative aspects of programing--rather than to quantities of personnel or funds. Better coordination among a vast array of diverse agencies is a repeated theme. In fact, so complex are the needs for better orchestrating even the presently existent services for children that the Task Force felt its inquiries should be continued in some form, possibly on both a state and regional level. This might tie in with a proposed Joint Commission on Mental Health Services for Children which, it now appears, will probably be established on the national level. It is evident that the former Joint Commission on Mental Health and Illness left much undone in the realm of children's mental health needs.

BASIC RECOMMENDATIONS:

I. The Mental Health Needs of Children:

1. The basic task is to build better generations! A child and his family "are together in bonds strong as steel, even in grossly pathological situations"— hence, an astonishing number of social institutions affecting the quality of family life must be systematically examined and -- somehow -- better coordinated if the continuum of services children need is to be improved.

2. The classic levels of prevention are closely interlocked -- effective intervention at almost any age level (childhood, adolescence, young parenthood) may be "primary prevention" if it interrupts the transmission of pathology to a new generation.

3. Present mental health services are most easily utilized by middle class families. New and imaginative ways must be developed for "reaching out" to lower socio-economic groups, especially the multi-problem families of the disadvantaged.

4. Children from minority groups represent a special population in great risk of suffering mental disorders -- health and educational personnel assisting such children require specialized knowledge if their efforts are to be genuinely effective.

5. Children without adequate parents constitute a second, partially overlapping population at risk, deserving major efforts at rescue. Colorado has made strides in providing such children with substitute parents or group living situtations -- but present staffing and training in placement agencies are insufficient, case loads are often far too high to permit effective work, foster home placements shift too rapidly, facilities for adolescents are extremely limited, even adoption processes are unnecessarily slow due to staffing shortages.

6. Many more points of intervention for strengthening the mental health of our children can be found -- really adequate feedback, an improved capacity for extracting new knowledge from our various treatment efforts and ploughing it back into the system, is both feasible and crucial.

II. The Role of Formal Mental Health Agencies:

1. In most areas of the state, existing services should be greatly expanded rather than new services created (but some size limit should exist!).

2. Communication, collaboration, continuity of care are basic problem areas for most agencies serving children. Mental health agencies should take leadership and a deliberately active role in improving these facets of inter-agency relationships.

3. Consultation is an urgent need for a wide variety of agencies and professions serving children. Much is now rendered but larger amounts of mental health staff time should be reserved for this activity in most regions.

4. Children can be reached by a wide variety of agencies, professions, even lay volunteers -- but there is still a place for highly trained psychiatric teams specializing in the treatment of children. Child guidance facilities, often as components of multi-purpose treatment centers, are invaluable as specialized sources of treatment and places for training allied professionals.

5. Time should be reserved for psychiatric emergencies, for crisis-oriented treatment of certain emergent problems for which solutions cannot be allowed to wait, for crisis consultation with allied agencies. Such time should be balanced with longer-term treatment.

6. In general, creative methods for joint planning and joint treatment with allied professionals should be deliberately sought out -- the "diagnostic team" working out initial treatment plans for a child might sometimes include the pediatrician, the family physician, the minister, the teacher, etc. Similarly, summer camps can serve the emotionally disturbed if aided by mental health consultation, home visits can be made on behalf of mental health agencies by other professionals, etc. Treatment in isolation from allied agencies is often indefensible in terms of lost time, duplication of effort, and family bewilderment.

7. A variety of new treatment modalities should be added by mental health centers to the present core of outpatient and consultation services. Day treatment programs in particular, along with gradual development of short term and long term residential treatment (in that order of priority) should be developed.

8. Research and evaluation should be a basic task for the state mental health authority but should also be pursued in certain aspects by local treatment agencies. Public awareness of this critical need should be greatly increased if financial support is to become adequate.

9. Participation in community education and community planning to assist community leaders and allied agencies in identifying and better serving high risk groups should be a major responsibility for mental health agencies.

III. Allied Agencies:

1. Health facilities should be greatly expanded so as to ensure that all children enjoy maximum physical health -- for example, health staff should be more systematically trained to spot emotional problems among young mothers during prenatal contacts, "well baby clinics", and while children are still very young. Much prevention and much early detection of emotional problems can occur well before the child enters school.

2. Pre-school enrichment programs and "head starts" should be available for far more of the state's children than is now the case. Screening for emotional problems during such programs should take place routinely. Kindergarten should be available to all children!

3. Schools need to greatly increase their psychology and social work staff in almost all areas of Colorado., particularly in rural districts.

4. Ungraded classes for slow learners and the mildly emotionally disturbed, specialized classes for the more seriously emotionally disturbed, and at least twice as many classes for the mentally retarded as now exist should be developed throughout Colorado.

5. School facilities should be adapted to the physical needs of physically handicapped children, many of whom are deprived of the major psychological advantages of attending school with other children due to inability to function in schools with antiquated architectural features.

6. Major additions to school curriculum could specifically aid in better preparing children for the inevitable crises of later life -- realistic vocational training for potential dropouts, sex and family life education, live contact with community agencies serving people through "fieldwork" experiences in high school, etc.

7. Welfare and placement agencies desperately need more resources for increasing staff, recruiting foster homes (especially for minority children), and for operating group foster homes (especially for adolescents).

8. Correctional agencies and youth rehabilitation services need to be greatly strengthened -- treatment time within institutions should be geared to the needs of the child rather than be governed by shortages of space and staff; a receiving center for appropriate evaluation studies should be established; judges and probation officers need more training in mental health resources and techniques.

9. For allied agencies, too, true program evaluation and research should be greatly strengthened. Feedback on the actual effect of different treatment procedures, placements, etc., is desperately lacking on a sophisticated basis utilizing scientific techniques and available computer technology.

IV. Coordination of Services:

1. The need for better coordinating services among the range of agencies serving disturbed families and children is obvious -- and has long been recognized. Nevertheless, past efforts have usually floundered. Unless sharply improved methods are developed, this problem is likely to worsen in the near future with the many new programs being developed to serve the disadvantaged, etc.

2. At all levels, effective progress at coordination and inter-agency planning requires staff time and the investment of special effort and skill. There is a need for both public and professional recognition of the fact that "planning," "community organization," "liaison," etc., are critical needs in their own right, needs whose ultimate fruits can have major impact on the quality of treatment received by individual patients and clients.

3. At the community level, interagency efforts frequently bog down because no one agency has staff to support committee work, to compile data, etc. Mental health clinics should endeavor to fill this need, where appropriate, by assigning specific staff to help lay and professional groups to implement community planning related to mental health. Larger mental health facilities may want to develop a new type of mental health professional whose full-time duties would be to work with allied agencies, supervise volunteers, VISTA workers, "indigenous non-professionals," etc.

4. Regional mental health boards, with a professional director, should be set up to receive and allocate federal and state funds so as to better coordinate local mental health resources.

5. At the state level, the psychiatric division of the department of institutions should be expanded in order to provide more effective planning with allied agencies at the state level, more consultation for expanding local services, more research (especially epidemiology and program evaluation), and more assistance in developing new innovations and experiments. As a start, an expanded staff could develop more effective coordinated planning through regular staff meetings with the Divisions of Mental Retardation, Corrections, and Youth Services.

6. Future consideration should be given to the potential advantages of establishing a State Department of Mental Health, the phrase "Institutions" being less and less appropriate for an organizztion whose prime mental health tasks are now to stimulate community-level services rather than state-level institutions. Such a department would work toward coordinating such closely-knit programs as delinquency prevention, services for the mentally retarded, joint programs with Public Health Departments and schools, etc. All of these are primarily areas for community-level action rather than isolated state "institutions".

7. An Advisory Committee focused upon childrens' mental health should be established to help the state mental health authority identify "high risk" groups of children, develop impetus in meeting their mental health needs, and work toward better solutions for the most urgent and basic task of all: efficient coordination of existing services which affect children.

REPORT OF THE TASK FORCE ON THE NEEDS OF EMOTIONALLY DISTURBED CHILDREN IN COLORADO

INTRODUCTION

Within the framework of comprehensive mental health planning for Colorado at this critical time, the urgency of adequate provision for the needs of children cannot be overstated. Today the mental health needs of children have come into focus around the democratic ideal of building better generations of the future. State and national leaders have expressed their recognition of society's responsibility for the healthy development of its children and indeed, the community's absolute dependency upon a reservoir of physically, mentally, and emotionally healthy and mature citizens. This recognition goes hand in hand with the free society's belief in the dignity and worth of the individual, adult or child and with the commitment of the state and nation to the right of each child, regardless of race, creed, or color, to the opportunity for healthy development and for adequate educational and vocational preparation.

In the content of these broader philosophic commitments to the promotion of mental health and the prevention of mental illness, significant strides have been made in Colorado, at state and local levels, and by public and private agencies, in the provision of mental health services to adults and children. Individual communities have come increasingly to recognize the importance of adequate children's psychiatric services, in the light of their awareness that the early treatment of childhood emotional and mental illness can contribute significantly to adult mental health. Educated citizens are coming to understand that, in various ways, the major types of services available today can help to achieve the ultimate and over-riding goal of prevention at one or another level: the reduction of the incidence of emotional and mental illness in children (primary prevention); early case finding and immediate treatment (secondary prevention); and the limitation of the disabilities attendent upon chronic emotional illness through rehabilitation (tertiary prevention).

The idea is being grasped today that there are powerful forces which transfer health or pathology across the generations; distortion, discontinuity, or insufficiency of parent-child relationships can, together with other influences, support the development of pathological trends over which parent and child ordinarily have no control. It is further apparent that parents and children are closely interlocking in their relationships, and that it is not possible for serious or deeply troubling events to affect one without the other. Thus, primary, secondary, and tertiary prevention are more difficult to separate in approaching childhood problems. Early

case-finding and treatment (secondary prevention), for example, whether it be with an adolescent, a young child, or the parents, has the potential effect of primary prevention, in that it interrups the transmission of problems to a new generation. It is clear also that communities are made up of smaller, interdependent groups, and that discriminatory forces affecting detrimentally the mental health of particular minority groups inevitably have an unwholesome impact upon the larger community.

In spite of such growing understanding and activity within Colorado, large gaps in needed mental health services for children remain. In the following discussion of such needs and ways of meeting them, an attempt will be made not only to indicate new or additional services required but also ways of coordinating and rendering more effective existing services. In addition, priorities in degree of importance and urgency of particular problem areas will be suggested wherever possible.

It is proposed to arrange the discussion around the following four topic areas. These topics, admittedly with some overlap among them, represented areas of concentration for sub-committee activity within the Task Force. Members of different disciplines from a representative group of agencies concerned with children's mental health needs made up the four sub-committees corresponding with these topic areas; their deliberation, summarized herein, drew upon data made available in the course of the present planning project, as well as upon their own professional experience, knowledge, and convictions.

1. The range of "<u>needs</u>" and "<u>services</u>" which society ought to provide for the prevention or treatment of emotional disturbance in children, and the extent to which these are available today in Colorado.

2. The roles, basic responsibilities, and primary missions of <u>formal mental health agencies</u> (including state and local health authorities) in preventing or treating emotional disturbance in children.

3. The roles, basic responsibilities, and primary mission of <u>allied agencies</u> in preventing or treating emotional disturbance in children.

4. Methods or devices for <u>coordinating services</u>, especially on the community level, for emotionally disturbed children, including responsibilities for leadership and community planning.

1. The Range of Needs and Services

An optimal mental health program for children, whether at the state, regional, or local community level, should involve a complex of services which are functional components in a continuum. At the regional or local level, it may exist within a comprehensive mental health center, with facilities for adults as well as children, but it may with equal validity represent a coordinated program among a variety of agencies within a geographic area. Such a program should offer diagnosis and treatment, provide consultation to a wide range of community agencies, offer training for personnel in numerous disciplines, initiate research and continuing self-evaluation, and employ public health approaches to data gathering and preventive activities. Construction of new physical facilities may be called for; however the essential focus should still remain upon services and personnel, not upon buildings.

The program should be seen as a integrating force; its concern should be with functions and goals, with filling gaps, with encouraging consultation and collaboration among agencies, and with helping to establish organizational relationships. Thus community efforts may be coordinated to provide diagnostic and treatment services and to reduce or prevent emotional disturbance or mental illness in the childhood age range.

Such a program should be organized so that it can make available a wide range of appropriate services to all children who are suffering from or who may develop significant emotional problems. The ideal underlying principle, as in the over-all community mental health program, is that the right child and family should receive the right kind of service, at the right time, and in the right place.

Planning for treatment or other services is predicated upon sound diagnostic study and evaluation. Competent psychiatric diagnosis of the child should involve consideration of this physical health and neurological status in addition to his patterns of intellectual, emotional and social functioning. Thus the work of the traditional child psychiatric team -- psychiatrist, psychologist, and social worker -- must be augmented by the contributions of other professional persons. The services of pediatric, neurological, and other medical consultants must be utilized as needed; the observations of teachers, public health nurses, welfare workers, and others who are familiar with the child's home setting as well as school and social performance must be drawn upon wherever feasible. Diagnosis should be seen as an on-going operation that merges with appropriate treatment, ideally in the same setting if at all possible.

Diagnostic services can also help referring agencies to clarify their treatment goals with the child and his family or to arrange appropriate placement services.

Services should be differentiated in relation to age needs and other factors. The geographic area within which the program operates -- rural, urban, suburban -- and the social, cultural, and economic background of the child patients and their families will have a direct bearing on the services needed and even the therapeutic or preventive approach.

In the recent past, the majority of emotionally ill children in the middle socio-economic group have been cared for in out-patient facilities; in contrast the majority of children from the lower socio-economic group, with its multi-problem families and its culturally deprived children, have tended to reach psychiatric clinics largely through referrals from juvenile courts and welfare agencies; they have been cared for principally in correctional institutions and in homes for neglected or delinquent children. Most of the parents of this latter group have difficulty in recognizing psychological disturbance in its initial and less dramatic forms, and are frequently not motivated in the expected fashion to seek psychiatric help. Successful work with these children and their families calls for a multiple approach and for active collaboration by formal mental health agencies with schools, welfare agencies, juvenile courts, family courts, settlement houses, and day nurseries, and with public health nurses, practicing physicians, neighborhood recreation workers, group leaders working with street gangs, and other personnel. New and imaginative ways are now being developed for "reaching out" to these children and their families and for determining their needs; these are being applied by formal mental health agencies and by allied agencies in the context of the Poverty Program in particular.

Components of An Ideal Program

Ideal formal mental health facilities for children and adolescents today include: out-patient clinics for diagnosis and treatment, both specialized child guidance units and all-purpose mental health clinics for the treatment of both adults and children; in-patient facilities, of diagnostic and short-term treatment character, as well as long-term "open" residential treatment centers and "closed" hospital units, together with specialized programs for seriously disturbed adolescents, mentally retarded children, and children with sensory handicaps such as blindness and deafness; day treatment centers with combined educational and therapeutic components; and therapeutic nursery schools.

Ideal facilities provided by allied agencies include: adequate foster home services, often difficult to arrange for minority groups, supplemented by specialized foster home settings or small group settings for adolescents, mildly disturbed children, and children with chronic physical illness or handicaps associated with emotional problems; cottage-type group living settings for older dependent children and adolescents, with adequate mental health consultation and treatment facilities as necessary; well-staffed nursery and day care units for children of working mothers; adequate recreational and related programs for children in under-privileged neighborhoods.

Adequate diagnostic, consultative, and treatment services should be available to schools, courts, prenatal, well-baby and well-child clinics, and institutions for mentally retarded and delinquent children.

The Situation in Colorado

With such an ideal program in mind, in line with national mental health goals for children, one can view the situation in Colorado at the present time. In this state, children of 18 years or under (649,000) formed 37% of the total population in 1960; an estimate is made that by 1970, this group will approximate 43% of the total (over one million children and adolescents). Although exact incidence-prevalence figures for mental and emotional disturbances in the childhood age range are not available as yet in Colorado or in many parts of the nation, some estimates can be made. Surveys of school populations in several cities in other areas of the country indicate that from 7 to 12% of the school age group had significant emotional problems which needed professional help. No comparable data is available for pre-school children, but it is known that most later childhood problems have their origin in the pre-school years. Using even more conservative estimates than the above (5-10%), it could be stated that from 30,000 to 60,000 children, presently under the age of 18 in Colorado, may be expected at some point in their development to require some type of professional help for emotional difficulties.

Further estimates have been made on the national scene to the effect that from 10 to 30% of the children in schools throughout the nation have some degree of educational disability; most of these require, if not formal psychiatric treatment, at least some consultation from mental health professionals. The incidence of school "drop outs" throughout this state, in the age group from 16 through 17, is 14%, with a 20% figure in Denver. This represents a total of over 53,000 adolescents, for many of whom, along

with appropriate educational steps, mental health consultation may be exceedingly important. This set of figures must be considered in relation to the rapidly increasing enrollment in school, with a 55% increase in the state population under 18 between the years 1950 and 1960, as opposed to a 32% increase in the total population.

In Colorado, as throughout the nation, statistics indicate increasing figures for divorce and family breakdown. At least one of every four marriages now break up through divorce. Although many of these are marriages in the post-adolescent age bracket without children, a large number of children still are affected. In this state, of mothers with children under six years of age, 6.4% have no husband present; in Denver, the figure is 9.4%, or about one-tenth of this group. In addition to marriage counselling or other services to prevent family breakdown, mental health consultation is urgently necessary for many of the children and parents so affected.

In the face of these staggering, only partial, and still increasing needs, the inadequacy of present facilities in Colorado, as in many other parts of the nation, is striking. The generally recommended ratio of all-purpose mental health out-patient facilities, serving both adults and children, is 1 to 50,000 people. In the Denver metropolitan area, however, where the bulk of Colorado's population is concentrated, the ratio is only about one such facility to 200,000 persons. Many counties in the state have no such facility; even on a regional basis, mental health consultation for children may be available to the citizens of numerous counties for only several hours per month. Within the Denver metropolitan area, there are only two specialized child guidance clinics, and such are even more sparsely distributed in other areas. Although estimates vary, at least one child guidance clinic per 200,000 population has been recommended.

Hospital facilities for severely disturbed or mentally ill children in Colorado currently amount to only a few more than 100 adequate beds in public institutions, although the potential of the newly organized Fort Logan Children's Mental Health Center will raise this to about 200. There is only one private residential treatment center in the state, in addition to several residential programs with psychiatric and psychologic consultation which will take mildly or moderately emotionally disturbed children. Adequate facilities for hospitalization of adolescents and of seriously disturbed children with special sensory problems or with mental retardation are virtually non-existent. Although newer techniques of treatment, such as that offered by day treatment centers, of which

several now exist in Colorado, can constructively cut down the use of hospital in-patient facilities or residential treatment centers for severely disturbed children and adolescents, the available facilities of this kind in Colorado are still grossly inadequate, according to national estimates. No therapeutic nursery schools exist at present in the entire state.

Moving from formal mental health to allied agencies dealing with children, certain data are available. There are approximately 30 public and private institutions, including the State Children's Home--many of them too large by current standards -- which provide residential services for dependent children. Of these institutions only 11 are known to have at least some psychological services available to them, and most have little or no psychiatric consultation, with limited social work staff as well. This observation fits with those regarding public and private child placement and welfare agencies. Underpaid staff workers with little mental health training in these agencies generally have child case loads which are much too large for anyone to handle effectively, even though nearly one-fourth of such dependent children have been estimated to be significantly disturbed emotionally.

Although valiant work in finding foster homes is carried on by public and private agencies, such homes are all too frequently inadequate, particularly for children of minority groups or those with some emotional disturbance. Principally because of limitations in staff supervising such placements, frequent moves from one foster home to another are seen. Data gathered on the use and effectiveness of foster homes throughout the nation indicates that a high percentage of foster home children experience three, four, or more placements, and that children placed for as long as a year and one-half rarely return to their own homes. Specialized foster homes or group facilities for older children and adolescents or for those with special problems, although beginning to be developed in Colorado, are extremely limited in number.

Because of insufficient staffing, there are at present at least three hundred children awaiting adoption, simply because of the need for home studies of prospective adoptive parents. The potential damage to personality development for children experiencing frequent foster home placement or prolonged stay in large institutions awaiting adoption needs no further documentation today, in the light of many studies throughout the world.

In addition, nursery and day care units for children of working mothers are largely custodial, with insufficient and inadequately trained staff available. Even community nursery schools, of parent-cooperative or wholly professional nature, are relatively rare in Colorado, and there is no university program for the training of nursery school teachers in the state.

Although consultation can frequently be arranged by referral to a clinic facility, often at long distance, most school systems, nursery or day care centers, courts, public health clinics, correctional institutions or institutions for the mentally retarded have extremely limited if any psychiatric or other mental health consultation in their own settings, even though many of the emotional problems of children under their care could be managed appropriately by such means. A survey indicates that less than half of Colorado's children receive comprehensive well-child supervision; most of those seen by private physicians or in public health clinics are probably in the infancy or pre-school age period. The national average of children who are not receiving such supervision has been estimated to be about 30%. Leaving aside adequate counselling to prevent emotional problems, basic physical health care, including appropriate immunizations, is not available to more than half of the children in the state, with all the implications this lack may have for the development of mental health problems associated with physical illness.

In relation to the school systems specifically, some psychiatric consultation is available to the public schools in the Denver Metropolitan area. Very little if any is available to most other school systems throughout the state. In the Denver public school systems, the present ratio of school psychologists to pupils is approximately 1 to 7,000 students, in contrast to recommendations by professional bodies for a ratio of around 1 to 2,000. The Denver public schools are well supplied with social workers, with a ratio of 1 to 1,600 students in general and 1 to 1,300 in the underprivileged areas. Denver's social worker ratio is thus an optimal one in the eyes of professional bodies and is better than the national average of 1 to 2,000. Outside the metropolitan area, however, except for Colorado Springs, which is also well supplied, there are virtually no social workers or psychologists in the school districts. Even in Denver, the parochial schools have very little in the way of psychiatric, psychological or social work services.

Some recent experimental steps have been taken to set up special classes for emotionally disturbed children in several school systems in the state. Most have no such programs, nor do they have special or ungraded classes for slow learners. Many do not even have sufficient special classes for mentally retarded children; in Denver and throughout the state, there are classes for less than half of the known retarded children. Adequate educational facilities are available for only about one-tenth of children with handicaps in vision or hearing in the state. Although a beginning has been made at the university level in Colorado in setting up training programs in special education for teachers of emotionally or mentally handicapped children, these are so far markedly limited.

The importance of kindergarten and pre-school experience for the learning readiness of underprivileged children in particular has been pointed up recently in connection with the Poverty Program and Project Headstart. Although kindergarten experience is available to a little more than half of the children in Colorado, which is above the national average, nearly half of the children in this age group --and these largely the children from underprivileged and minority groups who need it most -- have no such opportunity.

In the face of these tremendous needs, the manpower shortage in Colorado, as throughout the nation, is appalling. There is only one training program for child psychiatrists in the state; training facilities for clinical and school psychologists and for social workers are more extensive but still seriously limited. Mental health training opportunities are extremely scare for pediatricians, general physicians, hospital and public health nurses, teachers, welfare workers, child care workers, occupational and recreational therapists, and other professional groups involved in agencies allied with the mental health approach. Even where adequate funds are available for new positions in formal mental health agencies, recruitment from persons from within Colorado is difficult and virtually impossible from without. Even in clinical units which have at least adequate staff for service, too little time is available for training and evaluative research, activities which are inseparable from service of the highest order.

Finally, in regard to the coordination of available services for children, much has been done and much remains to be accomplished. Through the leadership of the Psychiatric Division of the Department of Institutions and other state and local agencies, patterns of consultation, cooperation, and appropriate referral have been developed in various

localities and among a number of agencies, both public and private. Many children must still be referred to other agencies, however, for psychiatric, psychological, pediatric, or neurological services which might be brought to them in the setting of the original agency or institution with much greater benefit. A number of parents must still be referred to psychiatric agencies for individual treatment by agencies handling their children, when additional psychiatric consultation in the original agency might be more effective in their management. In addition to such fragmentation of families, restrictive intake policies by private or public agencies still contribute to needless duplication of services, to difficulty in finding the right 'slot' for children, or to problems in arranging after care for children placed in institutions.

Although some progress has been made, mental health clinics still are not accepting for psychological treatment many children with mental retardation or brain damage associated with emotional problems. Although they are beginning to wish to be more active in treating delinquent children, many clinics are still reluctant to do so because of the very real and time-consuming difficulties involved. For these and other reasons some agencies charged with the care of such children have been slow to refer them for such help. Children with mental retardation, blindness, or deafness in association with psychosis have difficulty in finding places in either the state hospital or special institutions. The mental retardation program at a number of points is still too far divorced from the mental health approach, even though it is recognized by all that children with mental retardation may have all types of major emotional problems and require most of the same services as the emotionally disturbed.

None of these continuing problems in collaboration and coordination of services is due to lack of knowledge, ability, integrity, or good will on the part of any of the formal or allied agencies involved. Rather most of them would seem to arise as the result of harassment on the part of overworked agencies, with their own particular commitments to past policies, or as the result of financial limitations or local pressures, together with the lack of clear-cut coordinating patterns or the means of evolving these within the community.*

* The data cited in this section were drawn from materials available from the State Planning Project, individual surveys carried out by members of the Task Force, from national surveys such as "Action for Mental Health","Planning Psychiatric Services for Children", and the Report of the President's Panel on Mental Retardation, and from individual monographs by professional persons such as Bowlby, Bower, Maas and Engler and Witmer. Appropriate references are cited in the bibliography at the end of the Report.

2. Role of Formal Mental Health Agencies

From the foregoing survey of needs in Colorado in relation to ideal services, it can readily be perceived that a significant increase in the total quantity of formal mental health services for children is urgently required. This applies to all types of services mentioned above, including out-patient clinics, both of all-purpose nature and specialized child guidance clinics, in-patient units, day treatment programs, therapeutic nurseries, and others. These will be discussed below in relation to individual types of services. As a fundamental principle, however, the expansion and improvement of existing services, within reasonable limits of size, should be the basic approach to the quantitative increase, as a beginning step. This approach has the value of building upon a basis in existing fact, rather than the premature setting up of new facilities for which the need may be unclear. The exception to this may be in those areas where there is no existing service to meet a serious need or in a geographical sense where important services do not exist in sufficient proximity to the people who need them. The importance of coordination of existing services in the most constructive fashion possible has been emphasized previously; this principle applies to the expansion of existing services, as well as the establishment of new ones, and will be discussed more thoroughly in the final section. In the discussion to follow, ways of improving existing services will be discussed prior to consideration of expanded or new facilities.

a. Communication

Although present practices provide for ready transfer of relevant information about patients from one facility to another, with the permission of the parents and with adequate protection of confidentiality, more use can be made of such information, with less duplication of history taking and diagnostic services. More active and immediate communication from one agency to another, in instances where families have already begun a contact in one setting or in the case of multiple referrals, can result in return of the family to the original setting, with less utilization of professional time and effort as well as minimal fragmentation of family approaches.

This is not to support the "clearing house" method of obtaining information, since this can violate confidentiality. More intensive use of telephone contacts prior to referral from one agency to another can also promote appropriate services and minimize family confusion and reduplication of services.

b. Collaboration

Increased collaboration among community agencies and professional personnel in regard to diagnostic studies and treatment planning can result in significant benefits to the families involved, as well as in avoidance of reduplication of effort and fragmentation of family approaches. The use of intake screening conferences, for example, can bring together the various agencies which may have been involved in the study of or service to a family, resulting in a decision as to which agency should assume primary responsibility and in the determination of the roles of other agencies. This is particularly important with multi-problem families, where as many as six to eight agencies may be involved in different aspects of the family's treatment, welfare services, medical needs, and the like. Out-patient facilities can provide treatment for parents of children who are hospitalized at long distances, if patterns of communication and collaboration are clearly established.

In the case of children with chronic illness or handicap requiring treatment for associated emotional problems, such collaboration based on communication can result in a more effective delineation of the roles of psychiatric and medical personnel and agencies in the managment of child and family. The clearing with the family physician of a referral of a family to a child guidance clinic by a school social worker can be an example of such collaborative effort, which may reduce conflict or confusion for the family, the physician, the clinic, and the school.

c. Continuity

Insofar as possible, an unrestricted policy should be established for the admission and transfer of children and families to various facilities by means of some cooperatively determined arrangement for clinical need. Such a policy should be maintained without regard to ability to pay; there should be no residential requirements other than those imposed by whatever regional plan may be used, with as few other intake restrictions as possible. Planning of this nature may be relatively easy if the various facilities, such as out-patient and in-patient ones, are part of the same mental health center. It can also be arranged by separate facilities if effective cooperation communication and collaboration are worked out on a voluntary basis. To the extent possible sustained use of the same treatment personnel in different facilities will avoid the disruptive effect of shunting the child from one professional person to another. An example of this would be the continuation of the work begun by the therapist from an out-patient clinic with a child referred to a near-by inpatient setting, throughout the period of hospitalization and during after care. Continuation of

work with parents by a social worker previously involved in another agency can be arranged, with appropriate communication and planning, in certain instances where the child is referred for treatment in a child guidance clinic setting.

d. Consultation

Increased mental health consultation by formal mental health agencies is urgently necessary for pediatric hospital units, well-baby and well-child clinics, schools, day nurseries, courts, nursery schools, correctional institutions, family and children's agencies, institutions for mentally retarded and other specially handicapped children, neighborhood centers, social agencies of a welfare and placement nature, and other community agencies. The background, training, and experience of the child psychiatrist in diagnostic and therapeutic work with children make him especially well-prepared for consultative activities. Other professional persons with special experience with children, notably clinical psychologists, psychiatric social workers, and public health nurses with mental health training, are also particularly suited to consultation work, as are general psychiatrists with some training in child psychiatry. Individual aptitudes and experience should be considered in the decision as to who should undertake consultative activities, as well as the nature of the setting and its needs for medical or non-medical consultation. The principle should be established that the child brought to consultative attention in any one of these settings should have thorough psychiatric, psychologic, and physical studies, in order to ascertain the most appropriate service steps.

Consultation may be oriented around a case presentation, in which the consultant discusses the case material prepared by the worker in the agency, occasionally interviewing the child or parent directly. Other types of consultation may be with agency workers, directed toward increasing their understanding of the problems presented by their clients, helping the workers deal with their own anxieties about handling specific cases, assisting them in understanding staff problems, and aiding in clarifying policies and practices of their agency, as well as giving their workers orientation in community planning and case finding. This latter type of consultation amounts to in-service training, and its case-finding aspects may have important preventive implications. Consultation may also be offered by formal mental health agencies in the broad area of community organization and program planning for children's services, as they involve public and private agencies at local levels.

Although the agencies in Denver and throughout the state of Colorado have offered leadership in consultative services, there is often insufficient time on the part of the staff for this important function. Consultation of all the above types is urgently necessary for agencies in parts of the state outside metropolitan areas in particular. Available staff time for such consultation should be an essential component of a comprehensive program for a mental health agency, as a planned and positive activity rather than as something left for extra time, as has frequently had to be the case. In addition to consultative arrangments by agencies, part-time psychiatrists and other mental health professionals at particular mental health facilities, or professionals in private practice may offer consultation to community agencies on their own time.

There has been a shortage of child psychiatric consultation time in the state, although this is being remedied in some degree by the Department of Institutions and the Welfare Department at the present time. Increased use of other mental health professionals in consultative activities should be explored, and training for consultation should be an essential component of students in the various disciplines mentioned above. Different patterns of consultation can be evolved, as has been the case in some other parts of the country; for example, a psychiatric consultant to a family and children's agency may not only supervise the workers in their handling of clients, but may offer drug therapy to children or parents as appropriate. Such an approach may prevent fragmentation of families by referral of children or parents to medical agencies for such additional components in treatment. Community pressures may require that the more highly trained and experienced persons in formal mental health agencies spend a much larger proportion of their time in consultative, coordinative, and supervisory activities than has been the case in the past in many instances. Consultation at local and regional levels can serve a catalytic role as well in encouraging the development of new and urgently needed facilities.

e. Diagnosis and Treatment

In arriving at a balanced diagnostic evaluation of the problems of the child and family, the contributions of the multiple disciplines noted above are vital. In general, more effort can be made to invite professionals other than those formally on the staff of the mental health agency to conferences achieving diagnostic evaluation. Such persons include family physicians, pediatricians, public health nurses, teachers,

welfare workers, clergymen, probation officers, boy scout and other activity leaders, workers in neighborhood houses, and other persons familiar with the functioning of the child and family. The addition of a pediatrician on at least a part time basis to the team in a child guidance clinic could result in more effective and integrated use of physical evaluations, as opposed to the necessity for referrals elsewhere for such examination in instances where no family physician is available.

It is important to provide as wide a range of treatment modalities as possible in each formal mental health agency setting, in order to avoid the necessity for referral elsewhere for partial therapeutic measures.

Also a balance of services is vital to meet the varying needs of differing patients and families. The recent trend toward emphasis on short term, "crisis oriented", or emergency treatment is a significant one. Such planned short term treatment has an important place in the roster of treatment services. Nevertheless, intensive, long term treatment up to one or two years or more is still indicated in a number of situations. Flexibility in treatment planning, rather than a rigid prescription of one mode of treatment, should meet the needs of patients most appropriately. More rapid treatment results can of course be achieved when problems receive early attention in a community providing a wide range of services for children. Close collaboration with other community agencies will make possible also a more effective balance between direct treatment and environmental therapy, including placement of children in foster homes, cottage-type group-living situations, special schools, camps, activity programs, and the like.

The newer concept of "reaching out" to multi-problem families from underprivileged backgrounds, who frequently do not have the education or motivation to involve themselves in the usual methods of psychological treatment, has been mentioned and will be further discussed. It is important to emphasize that some parents and children from such backgrounds <u>can</u> and do take advantage of such treatment approaches. Thus a stereotyped image of such families should be avoided.

The philosophy of treatment best suited to the needs of a democratic society should rest upon the assumption of a wish for help on the part of all who need it. Services should thus be made available on the basis of equal opportunity, regardless of the background or attitudes of the individual or family. A balance should be maintained between society's responsibility for the mental and physical health of children and the

rights of the parent or family. Within certain outside limits, defined by law, families should be free to accept or reject services. Where underprivileged families in particular cannot easily accept needed services, often because of their distrust and misunderstanding of "helping" agencies, reaching out to the neighborhoods in which they live and modifying traditional treatment approaches, with coordination among agencies and programs, can be of significant value to them.

In the following discussion of specific types of diagnostic and treatment services offered by formal mental health agencies for children, some indications of current and possible coordinative patterns will be set forth in the individual sections. Others will be discussed in the final section. One basic issue has to do with the types of units in which services are most effectively and economically offered to children. Formal psychiatric services to children in this country in the past grew out of the child guidance clinic movement. Individual communities have established such clinics, as voluntary or public agencies, and they have been set up by universities or by social agencies. It is clear today that smaller communities or sparsely populated counties cannot be expected to support such a specialized child guidance facility, and all-purpose mental health clinics have been set up, in this and other states, to serve the needs of both adults and children. Family and children's agencies, on a private or voluntary basis, also have come to offer psychologic treatment for children and families.

As a result of economic considerations and the shortage of trained child guidance personnel, particularly child psychiatrists, some persons have come to advocate the adandonment of further child guidance clinic steps in favor of the all-purpose clinic. It is true that such units have certain advantages in being able to treat parents as individual patients when necessary, without referral elsewhere. The treatment of disturbed children and adolescents, however, is a specialized approach, requiring training and experience which have not been available to the staffs of many all-purpose clinics. Child guidance units thus remain necessary in order to train child psychiatrists, psychologists, social workers, and other mental health personnel, who can offer specialized diagnostic, consultative, and treatment services to all-purpose clinics on a part-time or full-time basis and who can participate in research directed toward the development of new treatment techniques. As will be suggested later in regard to training issues, child guidance facilities can also offer training to general psychiatrists and other mental health personnel who staff the all-purpose clinics.

The pattern of the future may see regional all-purpose clinics expanded into community mental health centers, with a specific section for the study and treatment of children operated by specialized child guidance personnel; in urban areas, separate child guidance units in hospital, university, or other settings can importantly supplement service, training, and research endeavors. If the ratios to population of all-purpose and child guidance units earlier recommended are to be achieved, however, some local all-purpose clinics will still have to operate on a smaller scale. In such instances, the services of a consulting child psychiatrist and at least the part-time services of specially trained psychologists, social workers, and pediatricians, among others, should be available to the staff of the clinic; at least some training in the diagnosis and treatment of children and continuing in-service learning opportunities should be made possible for any of the basic staff involved in work of children.

f. Out-Patient Services

Such facilities include child guidance clinics, all-purpose mental health clinics, family and children's agencies, and certain other social agencies with a specific therapeutic orientation or counselling approach. Again the principle of diminishing restrictive intake policies insofar as possible is emphasized, even though specialization in approach does have important and necessary implications for service, training and research.

Treatment activities should optimally include individual psychotherapy for children, activity groups for children, interview group therapy for adolescents and parents, group and individual casework and psychotherapy for parents, and family therapy, drug therapy, and vocational guidance as indicated. The recent introduction of teachers offering remedial education in child guidance clinics, making available individual or group tutoring as indicated in relation with other therapeutic steps, has much to recommend it. The addition of therapeutic nursery schools and day-treatment programs to out-patient clinics with expanded staff, rather than setting these up as independent units, is an important consideration. A few child guidance clinics in other parts of the country have added in-patient facilities of short or long-term nature. Summer camps for emotionally disturbed children have been set up by formal mental health agencies, although these may be run by allied agencies with adequate mental health consultation. Many children with brain damage and mentally retarded children with emotional problems can be treated effectively with special techniques in out-patient settings, contrary to earlier impressions.

The out-patient clinic should also provide continuing after care for the child who is discharged from in-patient treatment, with plans for after care ideally set up prior to referral for hospitalization or residential treatment. Therapy for parents of children hospitalized at a distance can also be arranged appropriately. Plans for the individual treatment of the parent or parents as patients with individual problems or marital difficulties, rather than as parents in a child-focused approach can also be arranged where indicated. Such can often be arranged in a child guidance setting, if treatment is being offered the child, or, in an all-purpose clinic, by the staff handling adults, avoiding referral elsewhere if at all possible.

With the use of increased communication, collaboration, and coordination, as well as the help of expanded staff and the development of new community facilities, out-patient units can make significant steps toward reducing waiting lists, as indeed has already been undertaken in many instances. Less restrictive intake policies and a wider range of treatment modalities may be of value also in permitting the unit to arrange for some fairly immediate help for the family in need of it. This may consist of a planned short-term approach where indicated or of some substitute or interim supportive contact, pending provision for more intensive psychotherapy or whatever measures are indicated. Such may be planned by the staff of the clinic or may be worked out with referring physicians, public health nurses, school personnel, or other agencies, with the use of homemaker or other adjuvant services. Sufficient staff time should be available so that some can be kept in reserve for true psychiatric emergencies which do not demand hospitalization; panic states and school phobias in children and family crises represent examples of such emergency situations, requiring psychological "first aid" measures for child and family, including the flexible use of home visits and other measures.

Creative methods of dealing with referred patients who cannot immediately be taken care of on an individual out-patient basis are being developed, such as group intake and evaluation. Drug therapy has something to offer in this connection; the use of tranquilizing and other pharmacologic agents, however, should not be considered as a substitute for adequate study and appropriate psychological measures of treatment.

g. Day Treatment Programs

Evidence is accumulating to indicate that many, though not by any means all, children formerly treated in in-patient settings can be effectively handled in a day care or day treatment program. Such are built around a core of specialized educational experience, combined with individual remedial education, appropriate forms of individual or group therapy for child and parents, drug therapy, vocational guidance, and other services as indicated. The child may be in treatment during the day and return to his home for the night and for weekends. Thus the cost for this type of facility is less than for in-patient treatment. Long term programs of a year or two are necessary for seriously disturbed children; some experimentation has been undertaken with shorter term methods of day treatment, however, covering a period of a few months, for example, for the child excluded from school because of a more acute problem. The day care center may also serve as an after care resource for children who have been discharged from in-patient or other institutional care.

The pioneering developments in associating a day care program with an out-patient clinic in several situations in Colorado should be expanded to other settings whenever possible. In state hospital or comprehensive mental health programs, day care may be carried on by in-patient units as after care or as a separate treatment program. The use of 'night care' in such settings for children who can be in the regular public school programs during the day has value also, as has a type of week-care, with return home on the weekends. The importance of flexibility of transfer from one type of program to another, as well as the maintenance of close communication and collaboration, cannot be over emphasized in the use of day treatment approaches.

h. In-patient Treatment

In-patient programs may be independent centers or they may be units of general hospitals, public or private, or units of university medical centers. Some may be supported by voluntary or community sources, while others may be a part of a social agency, with psychiatric and other consultative services available. In general these programs may be sub-divided on the basis of short term and long term dimensions of treatment.

Facilities offering brief in-patient study and treatment are limited in number throughout the country, and are especially wanting in most parts of Colorado. Some children can be studied adequately in a

pediatric hospital unit, with psychiatric and clinical psychological consultation and with skilled social workers and other disciplines available. Treatment around family crisis situations or a program of treatment offering social stimulation to an environmentally deprived child who fails to thrive may be offered effectively in such pediatric settings. Other children may be so disturbed, their behavior so bizarre, or arrangements so difficult that they require psychiatric hospitalization; they may profit greatly from periods of in-patient treatment ranging from a few weeks to a few months. With such relatively short term treatment and with appropriate help for the family, such children may be able to return to their homes with day care or out-patient treatment as after care procedures. Many long term in-patient programs cannot easily accept such children, since a fairly rapid turn-over may be too disrupting for the core group of children.

There is a need for more facilities of this type, both in comprehensive mental health centers and in general hospitals, with adequate child psychiatric and other consultation and supervision. Such units are especially needed for early adolescents who experience difficulties without special programs of activities and schooling, along with treatment. Late adolescents can be helped in an adult in-patient unit, if specialized educational and recreational services are included. Such short term centers can act as way stations or "half-way houses" for children who may later move to out-patient facilities or who, conversely, may require more long term and intensive care and treatment. In addition to public and private settings of this type, there is a need for "semi-private" treatment facilities, partially subsidized by state or other funds to meet the needs of financially "in-between" families.

Long term treatment may range from one to two or more years in length for children who can respond. Some children, because of the severity of their mental illness, unfortunately require care for many years or until maturity or beyond. Placement in long term in-patient units should not be undertaken lightly, since such a step necessitates removal from home and most often from the immediate community. Long term in-patient treatment should only be undertaken when the severity of the child's emotional or mental problem, the severity of the family's disturbance, or the presence of behavior which is destructive or dangerous to the child or to others, is sufficient to warrant such a step.

disturbance and milder mental illness. As implied above, however, in the sequence of development of resources within a community, day treatment programs might wisely be developed first, in order to ascertain the needs for children requiring long-term residential treatment at a later point. Such residential units are extremely costly, with a necessary staff-patient ratio of nearly two to one, and can be developed only on a regional basis in most areas. This presupposes that children will be taken who live within a reasonable distance, so that their parents can make frequent visits. Cooperative arrangements with psychiatric and social agencies in the child's home town, for treatment of the parents in instances where longer distances are involved, can be worked out, but these are not easy to maintain in the face of the difficulties in communication and cooperation. In addition to the needs for residential treatment facilities for school age children, there is an urgent need in Colorado, as elsewhere in the nation, for such programs for adolescents, who do not mix easily with younger children. There is also a critical need for specialized residential care for emotionally disturbed mentally retarded children, for disturbed children suffering from sensory deprivation from blindness or deafness, and for brain damaged children with emotional or mental problems.

Hospital programs for long-term in-patient care in general involve children's units in state hospitals in Colorado and many other places throughout the country. Such units frequently have available "closed" settings with special provisions, including staff precautions, to prevent the child from harming himself or others, although the necessity for such an approach in well managed clinical settings appears to be less than was formerly thought to be the case. Such programs can offer significant benefits for severely mentally ill children and for some with marked brain damage, as well as other problems requiring long-term care and treatment. In the past, unfortunately, state hospital units have been used at times by communities to relieve parents, courts, and child-oriented agencies of responsibility for problem children. With the recent step in Colorado toward committing children to the Department of Institutions rather than directly to state hospital units, control of admissions can be more appropriately managed by the clinical staff, and delinquent or chronically acting-out children can be more appropriately placed in correctional institutions, with added treatment, educational and vocational facilities. It is still necessary to emphasize the responsibility for the child referred to a state hospital unit by the parents and the community or a designated community agency, thus encouraging planning for rehabilitation and after care instead of acceptance of dependency and institutionalization. Close communication

and coordination is necessary between the hospital unit and local agencies around plans for concomitant work with parents and planning for after care. Although voluntary admissions are now felt to be best for children in most instances, special planning with local agencies may be necessary for these children who fail to return from visits home.

The addition of day treatment programs, week-care programs, night hospital arrangements, and other newer and more flexible services can be of benefit to such units. Although they have been used in the past primarily as second echelon treatment units, with local or regional clinics as first echelon facilities, with these more recent developments state hospital children's units are beginning to take their place in the community as parts of comprehensive mental health centers, with out-patient facilities added, including short-term methods of treatment where indicated. Family care or group foster homes can be used, together with day care, as after care arrangements or half-way steps on the road toward returning home. Even with such additional methods however there will remain a reservoir of chronically psychotic children who have responded to maximum benefit and require long-term living care for many years. These may in the future be most appropriately cared for on a long-term basis in family care or group foster homes, with specialized personnel of at least semi-professional nature involved in living care and with appropriate consultation.

As indicated earlier, even the expanded facilities, including the Fort Logan Children's Mental Health Center, will not be adequate to take care of the needs of children requiring long-term hospital care. It will unfortunately be necessary for some time for some children and adolescents to be cared for on adult wards in state hospital settings until additional facilities are available. New units should be carefully planned and located nearer to metropolitan centers than is the case with the Pueblo unit, with a limit of no more than one hundred beds in such a setting. The newly developed training programs for child care workers are important steps, and greater use can be made of such personnel in the future in other settings, such as cottage-type group-living situations.

In both residential treatment centers and hospital units, patterns of coordination and disciplinary representation may vary. In a residential treatment center for emotionally ill children without physical or neurological problems, a psychiatric social worker or a psychologist may fill the administrative or coordinating role, with a child psychiatrist offering diagnostic, consultative, or treatment supervision services and being involved, with other disciplines, in the establishment of a therapeutic milieu and psychotherapeutic activities for children and

parents. In other medical settings, a child psychiatrist may most appropriately act as the coordinator; in the face of the current shortage of child psychiatric personnel, however, it may at times be necessary for a general psychiatrist with some child psychiatry training or a member of another mental health profession to act as the coordinator, with the child psychiatrist offering consultative and supervisory services.

Mention has been made of the need for provision for psychotic mentally retarded children, who presently cannot be handled appropriately at either the institutions for the mentally retarded or the state hospital units, thus "falling between the slots." Laudable plans are being made for the development of special programs for retarded children at Pueblo currently and for psychotic retarded children at Ridge; these will require added personnel and consultative services, however, with additional facilities necessary in the future.

i. After Care

Plans for after care of a child treated in an in-patient setting should be undertaken prior to the child's admission. The referring agency, often an out-patient clinic, or another community agency should be designated through collaborative planning as the responsible one in planning the child's after care, including necessary consultative or treatment services, educational planning, recreational and vocational guidance, and specific welfare services to the child's family when indicated. After care should counteract the tendency of the family or the neighborhood to exclude the child after he has been placed in an in-patient facility; together with concurrent treatment measures for the parents, it should aid the family in providing a healthier environment for the returning child. If these fail, other placement measures may be utilized if necessary upon discharge. Encouraging steps in the direction of after care planning have been made in Colorado with the cooperation of community agencies. The Pueblo Children's unit has developed the position of a staff coordinator, who makes such arrangements through visits to local communities and referring clinical facilities. Such steps should be encouraged and strengthened, since otherwise the in-patient experience may not have a lasting beneficial effect.

j. Training

The serious manpower shortage and the need for increased training in all the mental health professions at the present time has been

emphasized. Training activities are increasing throughout the country but are not yet keeping up with the needs. Expansion of existing training programs for psychiatrists, psychologists, and social workers is fundamental in Colorado, with state and local support provided for such training approaches, in addition to federal finances. New methods of recruitment should be explored, beginning at least at college undergraduate levels. Mention has been made of the need for partial training in children's work for general psychiatrists and other mental health staff working in all-purpose clinics, in addition to provision of specialized consultative services; several other states now provide a year of such training for the director of such a clinic. In addition, in-service training and special programs of education should be provided for other professional groups now beginning to work in mental health facilities including pediatricians, nurses, neurologists, teachers, and others. Consideration should be given to the experiments, elsewhere in the country, in the development of a new discipline of psychotherapists or child therapists, working under the supervision of established clinical diagnostic and treatment facilites. In Colorado, training of clinical psychologists and social workers in therapeutic work with children is already going on, with some experiments in training other professionals such as teachers, who have gifts for such work. The need for increased training of child care workers has been emphasized; the use of volunteers, already begun in certain settings, can be explored creatively, with more attention given to the types of training programs best suited to develop their capacities. As new types of services are developed, these will stimulate new patterns of training. Beginnings have been made by mental health facilities in providing special training experiences for members of allied professions who have contacts with children, including clergymen, attorneys and judges, general practitioners, and other personnel such as representatives of law enforcement agencies.

The community should be helped to realize that opportunities to engage in training stimulate the clinical staff to a higher level of performance; they also serve as an attraction for more able and well qualified staff persons. The extent and amount of training obviously depends upon the size and staff situation of the individual facility, and the nature of training will vary somewhat with the program's setting, goals, and philosophy. Large units, such as university centers, will have formal training programs with staffs specially assigned to this activity. In the smaller units, training will be on a less formal basis. The need for university programs to devote a larger portion of their time to training than community agencies, thus cutting down on

the amount of clinical service which they can offer to the community, in balance with their training demands, should also be clear to other agencies and community representatives.

k. Research and Evaluation

Research and evaluation activities will vary from formal and extensive programs in large centers to less ambitious ones in smaller centers. Regardless of the extent of the research activities, the staff of mental health agencies should be encouraged to maintain a questioning approach to problems which they encounter and should have sufficient time to follow up on such questions, however informal the investigative approach may be. In any unit, there should be a continuous process of collecting and assessing data needed to evaluate the effectiveness of the services provided. Evaluatory activities include systematic recording of significant data on the child patient and his family, as well as upon the nature of the services rendered; a definitive discharge diagnosis, together with an estimate of progress; followup of terminated cases, with an evaluation of predictions made at the time of discharge, and periodic self-evaluation of each component of the program, together with an assessment of needs and gaps in the continuum of services available.

In addition to evaluatory activities, other types of clinical research are particularly appropriate for formal mental health agencies. For example, such investigation is urgently required for children who commit homicide, children in late pre-adolescent and adolescent age groups who make suicidal attempts, and children who experience disturbances in personality development in deprived and multi-problem families. Systematic evaluation of alternatives to psychotherapeutic treatment, such as foster home placement, should be carried out as should more careful studies on a followup basis of the outcome of adoptive and foster home placements in the community.

As part of such a research approach, epidemiological assessment should be included, permitting investigation of the circumstances fostering the development of disorders in children who are given direct services. Study of each case treated in the program can lead to the recognition of causative factors in the community and to preventive steps dealing with the problems at their source. The identification of "high risk" groups can form a part of this approach, with specific measures devised to deal with these. Such epidemiologic study can most easily be carried at the state level, with personnel

available for this purpose. Each clinical unit, however, can adopt such an approach, with some time allotted specifically for epidemiological work on the part of a psychiatrist or psychologist who may devote the major part of his time to clinical service. In larger programs, an epidemiological unit may be included, with the devising of record systems which can provide demographic and other data of significance. Computer techniques can be of help in this activity; they are not the total answer, however, since to produce fruitful answers the computer must be fed significant questions. Shot-gun data collection methods have little value in this field.

Although public awareness is growing, it has not always been clearly understood that such research activities, as well as basic behavioral studies, represent a vital part of the approach to the attainment of more adequate treatment and prevention. Specific support of a financial nature must be given to this purpose, from state and local as well as federal levels, in order to encourage new developments, re-evaluate old ones, offer stimulation for the staff, and attract capable and well trained persons. Even in units where service must be heavily emphasized, some time should be available for this activity; research and evaluation should not fall into the little time left over from service.

Preventive Activities:

These have been referred to, at primary, secondary, and tertiary levels, throughout the body of this section, either directly or indirectly. They will be discussed further in the section following on the role of allied agencies. In regard to primary and secondary preventive activities carried out by formal mental health agencies in collaboration with allied agencies, such as schools, hospitals, welfare and other agencies, it appears most effective at this point to develop priorities for screening, consultation and appropriate treatment activities in relation to "high risk" groups. This would appear to be more feasible than attempting to assess and support the emotional and mental development of all children in the community. Such groups include children from broken families or children placed in foster or adoptive homes or in institutions for dependent children; children with chronic physical illnesses or handicaps, particularly those undergoing fairly long hospitalization; pre-school children with physical illness requiring even brief hospitalization; mentally retarded children; children born prematurely or with birth defects; children of unwed mothers or mothers who have had significantly emotional difficulty during pregnancy or have received limited prenatal care; those children without kindergarten experience; those who show reading, learning, speech, visual, or hearing difficulties or developmental lags in kindergarten or the early grades; those in families undergoing

crisis experiences; and those in the lower socio-economic group in general.

Some agencies in the community are already giving priority to such high risk groups; the intake policies of other agencies tend to exclude many of these children, on physical, economic or other grounds, and some attempt should be made within communities to coordinate policies of agencies so that appropriate screening, consultation, and necessary treatment can be made available to them readily. It is axiomatic that screening and early case finding approaches increase the number of referrals to existing mental health agencies. Plans for such preventive activity should thus be coordinated closely with the program for expansion of available clinical facilities.

Most formal mental health agencies are already playing an active role in community education, with a variety of methods being employed. Sufficient time should be available to the staff for them to carry out such activities without undue interference with other commitments; these include contacts with parents -- teacher associations, church parishes, Scouting groups, mental health volunteer associations, and other groups. The training of volunteer mental health workers may aid in these contacts. In general it seems more fruitful at the present time to confine this educational approach largely to one of informing citizens about mental health problems and needs, as well as ways of seeking help, although some understanding of children's emotional needs and adult mental patterns can also be helpful. Our knowledge of healthy child rearing practices and of ways of promoting optimal emotional development in the family remains still sufficiently limited to make these difficult and at times confusing topics for parents, unless sufficient time is available for extended discussion.

It is vital to involve community leaders in the phase of mental health planning, around their activities on mental health regional boards or in other ways. Some of the patterns of coordination discussed in the last section are pertinent to this challenge. In summary, within the existing network of formal mental health agencies, increased communication, collaboration, continuity, and consultation, together with less restrictive intake policies and a more flexible use of diagnostic and treatment facilities available, can make more effective present services. Expansion of the staff of existing agencies can make more time available for such collaborative activities, as well as training

and research. Adding new services to existing agencies can create a more well coordinated and balanced program within the community, prior to the establishment of new and urgently needed services.

3. Role of Allied Agencies:

The allied agencies mentioned have important contributions to make to the mental health program for children. The specific contributions of the differing types of agencies and ways of enhancing them will be discussed separately below. Certain general considerations can be applied to all such agencies. With few exceptions, all allied agencies could benefit from increased mental health training of an in-service type, provided, as suggested above, by formal mental health agencies at the state, regional, county and local level. Virtually all such agencies have needs for increased mental health consultation, both of an emergency and planned nature. All are in a position to identify "high risk" groups of children; some are in a particularly strategic position to deal with their problems, in a primary preventive sense, with the help of consultation, diagnostic and other services by representatives of formal mental health agencies.

The problems faced by children of minority groups, particularly Negro and Spanish-American, are encountered by virtually all such agencies; these are problems which must be looked at separately. Almost all children of minority group extraction -- and most particularly Negro children -- may be said to have some degree of emotional disturbance which can be traced directly to discriminatory experiences to which they are exposed, either directly or vicariously, through older siblings, parents, and other adults. Those who work with them must have a sound awareness of this factor. There is a need for special in-service training, for example, for teachers working with minority groups, to enhance their understanding of their problems and to provide them with methods of giving to these children the added ingredient that can help overcome their special ethnic disability as well as their additional disturbance. It is highly desirable for people working with minority children to have close contact and understanding with minority parents in order to bridge the gap between the two cultures. Personnel working in group homes and foster homes need special help in overcoming discriminatory attitudes, so that the minority child is not constantly reminded of what he should learn to expect in the way of different treatment, thus reinforcing his negative self-image.

The roles of the following types of agencies are considered, not in order of importance, but rather in order of the numbers of children whom they encounter and serve. The list is not meant to be an exhaustive one, but rather to include major challenges and contributions.

(1) Public Health Facilities

a. Prenatal clinics and Obstetrical units:

Increased attention should be given to women during the prenatal and early postnatal periods when many problems begin, and mental health consultation and counselling should be provided when necessary, in addition to needed social services. Clues to possible problems in the parent-infant or family relationship can be obtained by nurses and other hospital personnel during the lying-in period, and by the visiting patterns of mothers whose children must remain in the hospital because of prematurity or birth defects. Thus prenatal and obstetrical units can serve screening and case finding purposes of primary and secondary preventive significance. Increased mental health training of nurses and physicians can be of real value, as can the increased availability of well trained social workers in such units, with adequate psychologic and psychiatric consultation. More use can be made of group or individual therapy to mothers or families in such settings, through coordination of community mental health facilities. Many of the high risk groups mentioned can be reached in these settings, such as minority groups, under-privileged families, unwed mothers, and others.

b. Child health facilities:

As implied above, the amount, but more importantly the availability and the quality of child health supervision should be markedly increased, particularly for the underprivileged groups. This applies to physical care, immunizations, and the like, but also to the psychological aspects of well child supervision. Guides to developmental evaluation and screening have been developed for use by pediatricians, general physicians, and public health nurses in such settings in Colorado; in-service training in the use of such techniques, as well as in relation to other mental health concepts, should be more extensively provided and encouraged. Through the use of individual counselling by physicians and nurses, as well as by group methods of discussion, particularly in relation to associated nursery school programs, much help can be given to young parents in particular in rearing their children with confidence and effectiveness, even though specific techniques of child rearing applicable to all parents are not and probably should not be available. Training for pediatric, nursing, and other personnel in such settings should include understanding of the principles of referral of families to mental health centers, although the provision of increased mental health consultative services in these settings may

make some referrals unnecessary. It should constantly be kept in mind that earlier case finding, in this as in any other setting, calls for expanded child guidance and other mental health facilities to meet the increased number of referrals.

More effective collaboration and coordination of services of both the above types can be obtained in neighborhoods where families live, since the available evidence indicates that many families do not avail themselves of even nearby services. The development of neighborhood service centers, together with nursery school enrichment programs, in the context of the Poverty Program and Project Headstart can be of great help in such coordination. Clinics of both the above types with adequate mental health consultation can be set up in such settings, and their utilization by the neighborhood, particularly in underprivileged areas, encouraged by liaison contacts, such as are being developed through the use of volunteer or paid individuals or "leaders" in the neighborhood. In such centers, the opportunity to treat problems directly as well as to offer well child supervision should be available to the staff, since many such families do not readily follow through on referrals for treatment elsewhere.

c. Schools:

Mention has been made of the urgent need for increased consultative services, of various types, in public, private, and parochial school settings, with closer communication and collaboration with formal mental health agencies in the community. Certain other specific recommendations can be made.

Pre-school entrichment programs should be increased, particularly in the neighborhood centers in underprivileged neighborhoods. The importance of pre-school education and its effect upon learning readiness is such that ultimately such facilities may be part of a state-subsidized or public school program which would incorporate mothers as part of an adult educational program. Mention is made of the guided observation and demonstration groups set up in other parts of the country, at times using "successful mothers" as assistants to the professionally trained teachers and as models for younger or less experienced mothers.

Kindergarten facilities should be available for all children throughout the state, with transportation available to families if necessary. This is especially important for underprivileged children in families with limited motivation for formal education. Studies have shown that enriched kindergarten experience for such children, especially when built on a pre-school enrichment program, can increase motivation and capacity for learning in the early grades, with hopefully a preventive effect upon later school droupouts.

Screening of children in the pre-school, kindergarten, and early elementary grades should take place routinely, in regard to the early detection of potential learning problems as well as emotional difficulties of significant nature. As some experimental work in the Denver school system suggests, teachers can with appropriate training, carry out much of the screening themselves, with the help of psychiatric and psychologic consultants and with the use of available developmental data, family history of learning problems, screening of reading readiness, visual and language abilities, and similar approaches. In this connection, increased coordination could be worked out between child health clinics, which often have available such data, and school systems, through contacts between public health and school nurses. Due caution should be exercised in such a screening approach and consultation from experienced child psychiatric personnel should be available in order to avoid potential harm from mis-diagnosis or over-enthusiastic recommendations.

Early remedial education of individual or group nature should be provided, at reading-readiness levels in kindergarten or in the first grade; this would be more effective than waiting until the third or fourth grades as is now frequently the case, by which time such problems are often firmly solidified and the child has experienced failure in learning, with enhancement of a poor self-image and at times secondary emotional problems.

At least three types of special class facilities should be available in the public school systems.

(1) Ungraded classes for children who are slow learners or who have mild emotional problems interfering with learning. These would include some who have developmental lags in reading or writing readiness, as well as others with mild brain damage, handled with appropriate consultation.

(2) Classes for emotionally disturbed children. These can be set up in small groups with teachers with special training, often with the help of social group workers and with adequate psychiatric, psychologic and social work support. Some treatment can be offered for less disturbed children in such settings in coordination with classroom work of specialized nature; other more seriously disturbed children can be treated concurrently in community mental health clinics with close attention to communication and collaboration. With such an approach, a number of children can be kept in the school setting, rather than having to be excluded or placed in residential settings. Such classes can also be used as transitional placement for children returning to the school system from in-patient or day care programs.

(3) Classes for mentally retarded children. As implied earlier, at least twice as many such classes as presently exist are urgently needed. Children who are slow learners or who exhibit borderline mental retardation, often on the basis of emotional problems or cultural deprivation, should be separated in ungraded classes.

In addition to the above classes for children with particular difficulties in learning, an increase in the availability of classes for physically handicapped or chronically ill children is needed, many of whom have associated emotional problems requiring mental health consultation. The Boettcher school provides excellent education for such children, but it is difficult to place a number of children there because of the large group of applicants, and it is advisable for the child to attend a regular school if at all possible. Some such classes exist in school systems throughout the state, but increase in such facilities is necessary. The need for a ten-fold increase in facilities for children with visual and hearing handicaps has been previously pointed up. Many physically handicapped children in outlying counties are unable to attend school because of lack of nearby facilities. Cooperative regional arrangement should be worked out to permit the availability of funds for such transportation. Although a recent state law provides for specific architectural planning for the needs of handicapped children in new schools, many older schools urgently require changes, in order to eliminate features which seriously impede the adjustment and learning of such children.

An after-school program for children of families with limited motivation for learning, because of lack of educational background or economic opportunity, and for children of working parents should be set up, with considerable enrichment of their social, emotional and educational experiences. These can be coordinated with neighborhood service centers or other neighborhood activity programs already existing.

Mention has been made of a need for increased psychiatric consultation in most school systems, as well as the need for an increase in the ratio of school psychologists to school population in the metropolitan areas. Urgent action is required for the provision of school psychologists and social workers to all school systems throughout the state. In addition to direct contact with children with emotional or learning problems, such mental health personnel can offer valuable consultation and in-service training to teachers and to school physicians and nurses. Consultation of this nature should be made available by some method to public, private, and parochial schools. A certain amount of supportive therapy or counselling for children and parents can be carried out by such personnel in the school setting; in general, the more seriously disturbed children requiring more intensive treatment can be treated best in formal mental health agencies, with close collaboration with the schools.

In most school systems in the state, with some notable exceptions, the size of the classes is too large to permit optimal conditions for learning for the group as a whole or the flexible use of individual attention by the teacher to children with mild learning difficulties or emotional problems. Diminution in the size of classes and some lightening of heavy teaching loads will also be necessary in order to permit enhanced in-service training of the type recommended. The teacher cannot and should not be a therapist. Nonetheless, the increasing professional challenges for teachers today require efforts to increase their status in the community and to enhance the effectiveness of methods of recruitment of mature and decidated individuals -- goals even more important than any increase in the number of classrooms.

Certain suggestions can be made regarding course content with mental health implications.

(1) School-work-vocational programs should be provided in all school systems for early adolescents who are potential school drop-outs because of poor motivation or other problems of emotional or social nature. Programs of this nature are virtually unavailable in the state at present. They can be tied to enrichment opportunities, such as are beginning to be provided in the Poverty Program for potential drop-outs.

(2) Sex education should be available for children in the elementary school. This approach may vary in different settings, since such education is basically the province of the family, and a cooperative approach between teachers and parents is necessary in order to make such education effective.

(3) Other courses designed to aid the normal development of children and adolescents could be emphasized more heavily. These include courses which broaden the horizons of boys and girls of high school age such as those dealing with social problems, sociology, and psychology. The use of field work for such students in community oriented centers, well-baby clinics, and nursery schools as has been begun in the Denver public schools, is recommended. Courses of this nature can also include preparation for "family life" and human relations, as has been tried in some schools throughout the nation. Such course material can be used to broaden and supplement -- but not to de-emphasize or undercut -- basic academic subjects.

Other recommendations can be made regarding the training of teachers in undergraduate and graduate programs. Provision for the training of nursery school teachers is urgently required as a specialized field of concentration. For all teachers of young children,

courses in child development, psychology, sociology, and related topics would be of value. Although training in special education for emotionally disturbed, brain damanged, and mentally retarded children has been begun at the University of Colorado, in connection with the Day Care Center in Denver, and at Greeley, this is still on a very limited basis. Considerable increase in such opportunities should be available to teachers.

More in-service training for classroom teachers in the early recognition of learning problems and emotional difficulties should be arranged, as well as in concepts of classroom management, methods of collaboration with mental health personnel, and the principles of referral to community mental health agencies in cooperation with parents. Formal mental health agencies can aid in the provision of such in-service training, in concert with increased consulative personnel in the schools themselves. The screening of teachers for discriminatory attitudes toward minority groups is felt to be difficult, though important; in-service training in the understanding of the problems of such children is viewed as vital, however, together with the achievement of an emotional climate in the school setting which can lead to the elimination of such attitudes. Strengthening of the role of the State Department of Education will be of help in implementing many of the above recommendations.

(2) Welfare and Placement Agencies:

Mention has been made of significant problems in foster home placement, particularly for children in minority groups. Increased and earlier availability of mental health consultation for agencies would help to break up the cycle of frequent foster home moves. The development of small, well staffed group placement facilities for emergency and short-term usage would aid in avoiding the over-burdening of foster parents with twenty-four hour demands by anxious, confused children. Heightened use of homemaker service for families in crises from illness of the mother or other sources would make unncessary the temporary placement of many children, avoiding the chance of permanent disruption of parent-child relationships. More adequately staffed day nurseries and pre-school day care units in neighborhood service centers, with hours fitted more flexibly to the working day, could free many mothers on Aid to Dependent Children to become self-supporting, while providing adequate parent-substitute relationships and emotional and intellectual stimulation for their children.

More training of foster parents in those homes utilized would be of value, as would the enhanced usage of specialized foster home facilities. These include group foster homes for adolescents, with a

balance between urban and rural or ranch-type settings to meet the needs of individuals. Such can also be valuable for children with specialized problems, such as those with chronic medical illness or handicaps, employing adequate nursing and medical personnel, and those with milder emotional problems. Family and children's agencies and other sources can develop more "agency-owned" group homes of these and other types, staffed by trained personnel of professional or semi-professional background. The remaining large scale orphanages in the state should be eliminated in favor of smaller, more home-like cottage type group-living institutions for older children and adolescents, with sufficient mental health consultation available. Children should be placed for adoption as soon as placement is available. More use could be made of summer camps for children with mild emotional problems, with specially trained personnel and adequate consultation, often arranged in collaboration with formal mental health agencies.

All of the above steps will make necessary increased mental health training of workers in such agencies, together with increased staff and better salaries for those in public agencies in particular.

(3) Institutional settings:

These include institutions for the mentally retarded, correctional institutions, and some institutions for dependent children, such as the State Children's Home. As implied earlier, all of these require added consultative mental health services in order to add a more comprehensive treatment-oriented, rehabilitative and educational approach to their programs. Closer involvement of the State Department of Education in planning for such settings is important. Most of these institutions are over-crowded, and additional facilities are necessary, which should be smaller and more regional in character.

Mention has been made of the need for development of special programs for emotionally disturbed children in these settings; the recent provisions for more ready transfer from such institutions to state hospital units, worked out by the Department of Institutions, represents constructive steps, but more children could be managed in the original institution if adequate mental health services were available. In particular, the State Children's Home, which houses dependent children, many of whom have significant emotional problems and require treatment, could be made into an effective residential treatment center, with relatively little additional expenditure, by the provision of additional treatment staff.

Facilities are so overcrowded in certain correctional institutions that a stay of only a few months is possible for a delinquent child. Evidence has accumulated to indicate that a stay of one to several years can often significantly rehabilitate such children, with a significant saving to the state in avoiding long-term care and recurrent court costs, whereas a stay of a few months may be of little help. The length of stay should be geared to the needs of the child rather than to other factors. Increased staff time to make possible coordination for planning for after-care of children placed in such institutions, in concert with formal mental health agencies, can also make the benefit of such placement more lasting. Increased facilities for work-training camps for pre-delinquent adolescents are also urgently needed.

Although the step of committing children from courts to the Department of Institutions rather than to specific institutional settings has been a constructive one, significant problems remain, with difficulites in arranging particular placements promptly. A need exists for a well staffed receiving center, in which children can have adequate psychiatric diagnostic studies, in order to determine the most appropriate placement. Children should not be committed from courts in outlying counties to the State Children's Home; ideally they should have psychiatric evaluation in local or regional mental health clinics or in the Children's Diagnostic Center prior to any placement consideration of this nature. Consideration should be given to the possibility of the setting up independent professional study committees for the major institutions, in order to provide more specific aid in achieving these or other recommended steps.

(4) Hospitals:

Available evidence indicates that most children show at least temporary emotional reactions to hospitalization or illness. The possibility of more lasting and serious reactions is high in pre-school children, who are most troubled by the separation from the family involved in hospitalization, and in previously disturbed older children, who react more sensitively to the experience related to illness or boidly mutilation and the necessary treatment approaches. Increased mental health training for physicians, nurses, occupational and recreational workers, and other personnel in medical settings can enhance their understanding of the reverberations within the child and family in relation to such experiences, with the development of more adequate preventive and preparatory techniques. The use of group discussions for parents of children with particular types of chronic illness or handicaps have been found valuable, among other approaches.

Increased psychiatric and other mental health consultation, both on an emergency and planned basis, should be provided to such settings, either through hospital staff arrangements or by community mental health agencies. The positive use of short-term hospitalization for diagnostic purposes or for the treatment of mild emotional problems has been demonstrated to be effective with the help of such consultation. Group foster homes, with adequate medical, nursing, educational and mental health facilities, or small cottage-type institutional settings can be valuable for children with chronic illness or handicap who cannot be cared for in the home. With the help of public health nurses and community agencies, as well as special school classes, many can remain in their own homes, and large convalescent homes or hospital schools are no longer indicated.

(5) Law enforcement agencies:

The challenges to correctional institutions have been dealt with above. Although encouraging developments in the juvnile court system in Denver have been seen over a number of years, many court systems throughout the state do not have judges adequately trained to deal with juvenile problems, and there may be little continuity of staff contact with children or adolescents. More in-service training for judges, probation workers, and other court personnel, as well as the provision of more adequate social work, clinical psychological and psychiatric services, is urgently needed. Detention centers are often over-crowded or under-staffed, with similar needs.

A closer cooperative relationship between courts and community mental health agencies should be strongly encouraged. Such measures as the arrangement for tutoring in basic reading skills for children on probation, who are often educationally retarded, the use of group therapy in court settings, and the setting up of child guidance clinics in courts for madated therapy, which have proven successful in other parts of the country, should be considered. Mental health agencies elsewhere, particularly child guidance clinics, have found effective the use of group therapy and other techniques for pre-delinquent children or older children and adolescents on probation, with close cooperation with probation officers. A clear recognition of the overlapping roles between the courts and formal mental health agencies, as well as the allied agencies, can lead to many constructive steps in addition to the above, including increased opportunities for formal treatment where appropriate evaluation of pre-delinquent siblings of children on probation, and other measures designed to reach multi-problem families.

(6) Training and Research Activities:

Allied agencies provide important training opportunities for students from various disciplines, such as social work or occupational or recreational therapy, who may be placed there for valuable experience by their own schools. In addition, special arrangements with formal mental health agencies may offer to their advanced students training in consultation and an important grasp of the contributions of such agencies. The opportunity to participate in such teaching can be of significant stimulation to the workers involved, and may aid in the recruitment of able and experienced persons.

As with formal mental health agencies, evaluative research by the staffs of allied agencies, both public and private, is of value, both in the achievement of more effective programs and in the stimulation of the staff. As indicated earlier, such agencies are in especially strategic positions to identify high risk groups of children, to study the effectiveness of various types of placement procedures, and to carry out other research activities, at times in collaboration with formal mental health agencies or available state or regional personnel. Increased staff time and training in such approaches will be necessary, however, to add this important investigative and evaluative dimension to the operations of many such agencies.

(7) Financial considerations:

Increased financial support of both public and private agencies is obviously necessary in order to accomplish many of the goals discussed. Patterns of financing will be discussed in the next section. As indicated in regard to formal mental health agencies, the community must be helped to see that the financial expenditures for adequately trained and sufficiently numerous staff, with increased in-service training activities, enhanced consultative arrangements, and appropriate evaluative and other research activities, are fundamental to the success of the mental health aspects of the work of such agencies.

4. Coordination of Services

Throughout the previous sections of the report, specific suggestions have been made for coordination of existing or planned services, particularly those at the community level. Most of these rest on the principles of communication, cooperation, collaboration,

continuity of services, and catalytic consultation which underlie effective work at any level, from local to county, regional, state, and federal levels. In this section, more specific recommendations will be offered regarding coordinative devices or methods, patterns of community planning, responsibilities for leadership, and patterns of financial support. Some overlap with previous sections, as well as some overlap within this section, inevitably occurs; it is hoped, however, that a section on coordination will pull together loose ends and aid in the integration of recommended steps. The discussion in all the previous sections is founded upon this basic principle. Without enhanced coordination, existing services cannot improve and new services will offer little help.

a. Methods or Devices for Coordinating Services

Concrete examples of such coordination have been given earlier, regarding the involvement of private physicians by school social workers in referral of families to mental health agencies, for example. Closer cooperation and communication of information, with the parents' permission, between public health nurses and physicians and school nurses and school physicians around screening approaches to early learning or emotional difficulties would represent another such coordinational step. Coordinative planning between an adult mental hospital which has treated a psychotic parent and a child guidance clinic which has been treating a child in the family, particularly as regards the timing of discharge of the parent, offers another example; parents have sometimes been discharged without the knowledge of the community clinic and in ignorance of the impact of the return of the still disturbed parent on the children in the family. Coordinative planning might result in a decision to keep the parent in the hospital for a longer period of time, since early discharge, with all its benefits, may have repercussions of unexpected nature.

In considering the need for coordination of services at the local level, there was recognition that numerous health, mental health, court, social agency, police, and other services have been frequently involved with the same individual or the same family, and that many failures have accompanied the presentation of multi-services to multi-problem families. In the past, coordinative efforts carried out by a group of agencies have run into difficulties, often after initial successes. The recommendation was made that all community mental health clinics should add to their programs a formalized division or individual to provide information-referral service to the public; to provide a research basis for evaluating the on-going service needs with the community, and to provide staff to help lay and professional groups implement community needs. This function would also work in the area of existing community

services, both for planning purposes and for individual case coordination. In this connection, the appointment of the case coordinator at the state hospital's children's unit in Pueblo should be noted, together with the lack of availability of staff time for these purposes in most settings. Work of this type could be carried out by existing mental health professionals with a knowledge of community facilities and resources. Such work could also be carried out by a new type of mental health professional with the consultation of clinic staff, thus saving the professional time of existing staff for other purposes. In some communities, a trained mental health professional coordinator could function as such and could in turn supervise volunteers, VISTA volunteers, or lesser trained assistants. It was seen that a community mental health coordinator of such nature could fulfill the fifth required service under the Federal Mental Health and Mental Retardation Construction Act, namely, providing consultation and education to the community.

At the level of the county or region, it seemed clear that the best plan for coordination would be that based on the system of mental health boards set up by certain other states. These may operate at the county level, and may involve a professional director, from one of the mental health fields, with the board composed partly of professionals and partly of lay leaders in the mental health field. In Colorado, outside the Denver metropolitan area, such boards would probably have to operate at a regional level, in the face of the fact that most counties have such small populations and limited funds; such regions have already been designated. Within the Denver metropolitan area, the political problems involved in county and city cooperation might make such a regional board difficult to achieve, and county mental health boards may be the answer there, with some cooperative planning and coordinative efforts among counties. With mental health boards of county or regional nature, federal funds channeled to the state and state matching funds for local expenditure can be employed in such a way, through negotiation of contracts with public, voluntary, and private agencies, as to coordinate an integrated system of services within the area. Such organizations as the Metropolitan Council, with its mental health planning committee, and local mental health associations can recommend to the mental health board action which they consider appropriate in the mental health area. The development of local or regional comprehensive mental health centers can proceed smoothly on such a basis, including appropriate children's services, and a healthy balance can be achieved within the area among the various agencies represented in the mental health program for children.

Coordination at the state level is exceedingly vital to the success of an over-all program for children or adults. It is especially important that coordination and planning be possible for the formal mental health authorities with those responsible for operations overlapping with the mental health areas, such as the Poverty Program and the Civil Rights Program; coordination must be achieved with other state departments such as Welfare, Education, and Public Health, as well as with regional offices of such Federal agencies as the National Institute of Mental Health and the Children's Bureau. In order to make possible such coordination, it is essential that the role of the present Psychiatric Division of the State Department of Institutions be expanded and augmented, so as to provide more effective state level planning and research and more consultation to local communities and regions. Evaluatory and epidemiological research at all levels can be initiated and encouraged by trained research personnel, as can clinical research at local levels; consultation to local clinics can be expanded in such a fashion as to encourage the development of new services in presently established clinics and to offer aid to those citizens who may seek to establish additional clinics in their communities. Such consultation can also assist both community and region in surveying their needs and developing coordinated methods of achieving required services. Experimental prevention and treatment services can also be encouraged in the community or region through the activities of such state level personnel, particularly those with community organizational skills.

As a first step toward such increased coordination, the achievement within the Psychiatric Division of such an expanded staff with augmented functions could be undertaken, together with enhanced opportunities for coordinated planning with the Divisions of Mental Retardation, Corrections, and Youth Services through regular staff meetings within the Department of Institutions. A more effective and far-reaching plan, however, would be the establishment of a State Department of Mental Health, as is being developed in a number of states. Such a Department would have responsibility for the administration of public mental health facilities; for the initiation and coordination of planning for services at all levels; for state wide public relations and public education; for licensure of formal mental health agencies; for the functions of a clearing house for information and resources; for acting as a reception agency for Federal funds and for disbursement of these and state funds to state, local and voluntary agencies through the regional and/or county mental health boards as appropriate; for the initiation and development of plans for training and personnel recruitment; and for research and evaluatory activities. As a part of such a departmental approach it would be helpful to have a Director of Research, Evaluation and Planning, who could assist in evaluating the effectiveness of different state programs and in promoting cooperation and coordinated planning among departments.

b. Patterns of Community Planning

With such a coordinational pattern as sketched above, surveys can constructively be carried out at local, regional, and state levels regarding mental health needs, leading to a flexible and creative planning approach to the expansion or consolidation of existing services and the development of new ones, avoiding a "more of the same" quality to planning. Knowledge available at the state level already, such as the very high rate of first admissions to correctional institutions on the part of young adolescents in region 10 and 11 or the strikingly high suicide rates in rural counties adjacent to heavily urbanized areas, could be taken advantage of constructively, with initiative by state personnel translated into action at the regional and local levels. Cooperation could be achieved in planning between the mental health and public health authorities in providing urgently needed comprehensive child health services, with adequate mental health consultation, to underprivileged groups; this could be planned effectively with representatives of the Poverty Program in setting up neighborhood service centers with such facilities involved. Personnel at the local level could be of help in establishing needed services, such as the provision of social work and psychology staff to schools, through the regional mental health board system, drawing on local funds as well as matching state funds. Although some uniformity in the establishment of needed services in all communities would be possible, the way would be left open for local differences in patterns of planning, with the incentive of available state matching funds to encourage regional and local initiative in planning. Cooperative planning could take place between city and county authorities around the functions of a comprehensive mental health center in a city hospital, for example, with the provision of services to county areas without facilities made through contractual arrangements for reimbursement, as has taken place in other parts of the country.

As far as state planning is concerned, it was felt that each region should ultimately have one comprehensive community mental health center, including out-patient facilities for children with specialized staff available, in addition to local all-purpose, mental health clinics and separate child guidance facilities in heavily populated urban area. At least two additional in-patient facilities for children and adolescents will be required in the state in the near future, appropriately placed both in regard to regional needs and nearness to urban communities.

c. Patterns of Financial Support

Many of these would flow logically, as they have in other states, from such a coordinational pattern as indicated above. Coordination at the state level, for example, could result in state tax funds being

made available for increased personnel and functions in correctional institutions. Needed local services, such as emergency psychiatric facilities for disturbed adolescents who make suicidal attempts, could be encouraged through the negotiation of contracts for personnel or services within the county or regional board system. These could be stimulated in private as well as existing public hospitals of general nature. Contracts might vary, in some instances involving the payment of salaries of urgently needed personnel, in others providing funds for a stipulated amount of service. Inter-county and even inter-state reimbursement for mental health services, special schooling, welfare, and placement services could be worked out more appropriately. The activities of private agencies who, in contrast to voluntary agencies, receive little or no support from state or local sources, can be augmented through specific contracts with regional mental health board representatives. Funds for training of urgently needed personnel, such as school social workers, as well as for in-service training for teachers, probation officers, and other personnel, could be provided from state and/or regional sources in the form of stipends or financial assistance.

The need for added public support of mental health activities is clear from the picture of needs throughout the state as formed by this and other task force reports. One sub-committee proposed the motto of "Match the Man in the Moon". Pointing out that the Economic Opportunity Act and the Head Start Program are excellent points of departure, they indicated that if the federal government could provide funds for education and mental health, together with a higher proportion of funds for needed welfare services, which were comparable in amount to those provided for the moon launching, on-going and new programs could take off the ground. A parallel philosophy should be supported at the state level, as well as regional and local ones, with expenditures for the mental health of our children, our most precious resource, at least matching those for highways and recreational facilities.

d. Responsibility for Leadership

If local, regional, and state activities were coordinated along some such lines as suggested above, it is apparent that different kinds of leadership would be necessary at differing levels. Formal mental health agencies have assumed considerable leadership at the local level, as has the Psychiatric Division at the state level. Although community leaders in business and professional groups have made

significant contributions on boards of private agencies in particular, it is highly important that the efforts of more such energetic and able citizens be devoted to the achievement of the goals of mental health programs if these are to succeed. Through a system of regional or county mental health boards, this can be accomplished, since such persons can and should be represented on the board membership. Greater involvement of local medical, pediatric, and other professional societies, through their mental health planning committees, can be achieved. More effective community education by such individuals and organizations, in concert with formal and allied mental health agencies, can encourage greater public support for expansion and new developments. Organizations such as WICHE, with its mental health program, can be supported to increase their mental health educational activities. In urban areas where a local chapter of a mental health association exists, concerned citizens and professionals can exert leadership through membership of the chapter in a local council of social agencies, which can recommend plans to the regional mental health board.

With such a regional system, and with the leadership of a State Department of Mental Health, local, private, and voluntary agencies could be stimulated to assume more responsibility for coordinated mental health planning. Through negotiation of specific contracts for new services, the more restrictive intake policies of certain agencies can be altered in the direction of meeting community needs, and a certain accountability without coercion can be introduced into community planning. Such an approach to cooperative and coordinated planning can prevent financial or power structures from developing within communities among public, voluntary, or private agencies. The special needs of university or teaching facilities can be interpreted more clearly to the community, in line with their need to tailor in-take policies to achieve a balance between teaching and research activities and the meeting of community needs. As has happened in certain metropolitan areas, in other parts of the country, mental health clinics may be helped to serve different geographical areas, while still retaining their individual identities, and to achieve a greater flexibility in intake policies without losing their basic function and roles. In Colorado, state authorities have already stimulated periodic meetings of community mental health clinics to discuss common problems and potentialities. In the children's mental health field, one possibility might be that some sort of Advisory Committee, with a make-up somewhat similar to this Task Force, might be set up, in order to stimulate discussion and coordinative planning on a voluntary basis, as well as to support the activities of an expanded and augmented mental health authority at the state level.

In summary, coordination of the efforts of existing mental health facilities represents the most urgent and basic step in the achievement of an adequate state-wide program. Needed expansion of existing formal and allied mental health agencies, along the lines suggested herein, can then take place in an integrated fashion, with the filling of gaps in formal services and provision of needed consultation and in-service training to various allied agencies rating high priorities. Thus the final step of developing new facilities, at local, regional, and state levels, can be built upon a solid foundation, with balanced attention to the needs of "high risk" groups and those of the emotionally disturbed and mentally ill.

Members, Task Force on the Needs of Emotionally Disturbed Children

Chairman, Dane G. Prugh, M.D.

Sub-Committee: Mental Health Needs of Children
Sub-Chairman, Wm. F. Finzer, M.D.

Dr. E. Ellis Graham
Dr. John Ogden
Dr. Henry Kempe
Dr. Dorothy Stillwell
Mr. Martin Nacman
Miss Dorothy Lynch

Sub-Committee: Formal Mental Health Agencies
Sub-Chairman, Dr. John Vayhinger

Mrs. Shirley Curtis
Dr. Robert F. Dibble
Dr. David Kaplan
Dr. Abe Heller
Mr. Eugene DeBellis
Dr. Don Bourg

Sub-Committee: Allied Agencies
Sub-Chairman, Mrs. Marilyn Rigler

Mrs. Ruth Davis
Dr. Frank Cozatto
Dr. Stewart Taylor
Dr. Tom Glasscock
Mr. Kenneth Joos
Dr. Frank Vaughn

Sub-Committee: Coordinating Services
Sub-Chairman, Judge Ted Rubin

Mr. Goodrich Walton
Dr. Arthur Warner
Mr. Robert E. Allen
Dr. John Conger
Mr. Melvin Philbrick
Dr. Robert E. LeLievre

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TASK FORCE ON MENTAL HEALTH SERVICES

AND JUVENILE DELINQUENCY CONTROL: Recommendations for Colorado

A Task Force on the mental health aspects of juvenile delinquency was set up by the State Mental Health Planning Committee in January, 1964. Chaired by Mylton L. Kennedy (Chief of Youth Services Division, Department of Institutions) this group included representatives from the State Department of Institutions, the University of Colorado, Western Interstate Commission for Higher Education, Denver Juvenile Court, Metropolitan Council for Community Service, and consultants from the State Judicial Department, State Department of Public Welfare, and the U. S. Children's Bureau. Data were developed by Mr. Robert Hughes, a graduate student in sociology at the University of Colorado. Opinions and advice were solicted from each of the state's 19 mental health clinics, the Children's Diagnostic Center, a number of District Courts, and assorted individuals from the corrections field in Colorado.

The Task Force gave emphasis to the fact that mental health services are only part of any real solution to the problems of the delinquent child. Other areas must be worked on, too, such as better opportunitites for recreation, vocational counseling and training, special education, job placements, etc. This report, however, deliberately focused upon mental health services.

SUMMARY OF RECOMMENDATIONS:

The following is a compendium of over 100 individual suggestions submitted to the Task Force, grouped into four major areas:

I. Mental health resources needed within the Youth Services Division.

II. Mental health resources within District Courts and their probation departments.

III. The optimum relationship between external mental health resources (those not directly operated by the courts or the Department of Institutions) and the field of juvenile rehabilitation in Colorado.

IV. Research, data systems, and program evaluation.

I. Mental Health Resources Needed Within The Youth Services Division Of The State Department of Institutions:

There are five areas for major contributions by mental health professionals to the Youth Services Division:

(1) Consultation on program development.
(2) Case management consultation.
(3) Training of other personnel.
(4) Direct therapy for selected cases.
(5) Techniques for program evaluation.

These are examined in more detail below:

1. Consultation on program development should be a major concern, inasmuch as environmental and group processes -- the treatment "milieu" -- probably have more impact on more inmates and parolees than available amounts of individual or group therapy.

2. Case management consultation as an aid in setting goals, managing treatment, and planning for parole follow-up should be a major and continuing function of mental health professionals in the Division. It is far more useful than diagnostic workups alone. In addition, it can serve a vital function in training staff in the dynamics of delinquent behavior.

3. Assistance in training personnel through participation in in-service training, case consultation, supervision of group therapy, etc., is crucially important. Relatively few persons in the youth rehabilitation field have advanced training. Even if future stipends and adjustments in university curricula partially alleviate this problem, staff training programs within institutions and for parole staff must continue to have high priority for years to come. Such training is particularly needed for cottage counselors and similar child care workers and should be along the lines developed for training workers in psychiatric residential treatment centers.

4. Individual psychotherapy should be used, but only where gains are likely within fairly brief periods. If long-term therapy for deep-seated intrapsychic disturbance is indicated, transfer to an institution for the mentally ill should be effected. It seems likely that only a small percentage of adjudicated delinquents require or would benefit from long-term psychotherapy.

5. Group therapy in contrast, seems particularly promising for adolescent delinquents and should be carried on directly by mental health professionals and indirectly through the training and supervision of other staff. It should be more extensively tried by juvenile parole as well as within institutional settings. Family counseling should also be given more emphasis.

6. Individual treatment relationships established within institutions should be continued during and after parole in carefully selected instances.

7. Participation in program evaluation and the development of research should be a routine function of mental health professionals within the Division.

8. To accomplish the tasks outlined above, present mental health resources within Youth Services Division are quite inadequate. Psychiatrists and clinical psychologists are currently available at each of the youth institutions only on a limited, part-time contractual basis. At a minimum, each of the institutions operated by Youth Services Division should have at least one psychiatric team (psychiatrist, psychologist, professional social worker). Psychiatrists are likely to continue to be available only on a part-time basis. With adequate inducements, full-time psychologists and social workers should be obtainable.

9. Eventually, a diagnostic reception center should be set up with residential facilities for extended studies of selected children by a multi-disciplinary team -- this service to be established primarily to enable the Department of Institutions to adequately evaluate children committed to its charge (a responsibility now spelled out in new statutes). Such a center might also supplement the present Children's Diagnostic Center at the Medical School which is primarily oriented toward teaching.

II. Mental Health Resources Within District Courts and Probation Departments:

1. Almost all courts and probation departments -- with the exception of Denver Juvenile Court and perhaps one or two other courts in heavily populated districts -- lack the capacity to finance extensive mental health services as part of their own treatment resources. Hence, most courts need access to exterior mental health services.

2. Larger courts, however, can develop their own staff for diagnostic evaluations, some group and/or family therapy, etc. In some instances, courts should share with clinics the salary expenses of such professionals. Liaison between courts, probation departments and clinics might benefit from such arrangements.

3. Community mental health clinics are potentially more useful resources for most courts than hiring their own mental health personnel or relying on the Children's Diagnostic Center for routine workups. Local clinics are likely to be more knowledgeable about local community conditions and hence better able to tailor their diagnostic recommendations to local realities.

III. Optimum Relationships Between External Mental Health Resources (those not directly operated by the Courts or Department of Institutions) And The Field of Juvenile Rehabilitation in Colorado:

1. Communication between professional mental health workers and workers in the field of juvenile rehabilitation often seems very poor. Differences in function (e.g., the courts and institutions' need to "safeguard society" through controlling misbehavior, in contrast to mental health's focus on "accepting" the patient who is motivated toward benevolent and disinterested help) lead to philosophical differences which sometimes seem large indeed. Nevertheless, the two fields have much to learn from one another -- a belief which seems especially strong in those few mental health professionals who have actually worked in youth institutions or parole settings.

2. Hence, at the state level a continuing functional relationship should be maintained between Youth Services and the Psychiatric Division within the Department of Institutions, the Children's Diagnostic Center at the medical school, Child Welfare, and major professional organizations in the mental health and correctional fields.

3. Youth Services should help courts and juvenile probation officers, as well as its own juvenile parole officers, to develop close working relationships with community mental health services.

4. Similarly, the Psychiatric Division of the Department of Institutions should help community clinics and other elements of mental health care to develop more useful relationships with local courts and probation and parole officers.

5. Joint service demonstrations should be explored in an effort to develop more effective ways in which mental health techniques can be used as an adjunct to the efforts of youth agencies. Service to the "multi-problem family," especially in areas of poverty, should be focused upon -- such families are presently major challenges for both mental health and youth rehabilitation agencies.

6. Diagnostic labels alone are an inadequate contribution for the mental health field to make toward the control of delinquency in our society!

IV. Research, Data Systems, and Program Evaluation:

1. Reliable data in a form adaptable to electronic processing have been largely missing in the field of juvenile rehabilitation. Adequate studies on the extent of "delinquency" in the various communities of Colorado simply do not exist at this time. Data for assessing in critical detail the types of delinquent populations being committed by the courts, and the efficacy of treatment programs, are similarly unavailable. Developing such data should have high priority, and the behavioral sciences should have a major contribution to make in this effort.

2. A form for processing uniform data from all District Courts on delinquents adjudicated by them and placed on probation or committed to Youth Services has been developed by this task force. Its use should continue to be co-sponsored by the Youth Services Division and the State Judicial Department. Resources for processing and analyzing its data should be developed by Youth Services and the Department of Institutions.

3. A full-time research staff serving the Youth Services Division and the District Court probation departments should be developed by Youth Services. At least one clinical psychologist or sociologist could serve as an initial member.

4. Relations between the juvenile rehabilitation field and the state's universities and colleges should be further developed, with major emphasis placed upon developing university interest in research and demonstration projects in the field of juvenile delinquency.

THE MENTAL HEALTH ASPECTS OF JUVENILE DELINQUENCY IN COLORADO: 1965

Adapted from Data Submitted by Robert H. Hughes

The relationship between mental health agencies and those whose prime mission is to control and reduce juvenile delinquency is strikingly ambiguous at present. At one extreme is a belief that most delinquents represent intrapsychic pathology which must someday be attacked by improved or altered mental health techniques. At the opposite is a conviction that the world of the delinquent is part of a cultural milieu so complex as to yield only to wholly new techniques for re-shaping society — abolishing its ghettos, its inequalities, changing its opportunity structure, its class levels, its distorted value systems.

Surprisingly, both extremes can be found in both types of agencies. For example, although treating delinquents was one of the principal goals of the early founders of child guidance clinics in this country (e.g., Judge Baker Guidance Center in Boston or the Institute of Juvenile Research in Illinois), few clinics today actively treat large numbers of adjudicated delinquent youth. When queried, most clinics in Colorado express a wish to be more active against delinquency -- but not by increasing their direct treatment of adolescent lawbreakers. Instead, consultation, diagnostic workups, inter-agency planning, direct treatment for "pre-delinquent" children are likely to be suggested.

Meanwhile, agencies with statutory responsibility for handling delinquents express highly conflicting attitudes about the use of mental health resources as allies. Some insist all or most delinquents should be "treated" as sick children by psychiatric teams. Others feel that few delinquents can respond with proper motivation or adequate verbal skills to the kind of psychotherapy offered by most clinics today. Apart from "diagnosis" (and treatment for a minority of grossly psychotic or neurotic individuals), they see no major role for the usual mental health clinic or consulting psychiatrist.

The purpose of this particular study was to attempt to gather facts on just what use is made of mental health resources by those charged with controlling delinquency in Colorado. Focus was upon the very few mental health personnel employed by state institutions for adjudicated delinquents; the use by local courts of community clinics and the Children's Diagnostic Center at the medical school; and ways in which mental health practitioners themselves feel they could be used by correctional agencies.

One fact should be clearly and explicitly stated: available data concerning delinquency in Colorado are woefully inadequate. Precise figures gathered on a uniform basis from all parts of the state do not exist. Data on age, type of offense, ethnicity, family background, ultimate disposition, concurrent action by allied agencies -- all this is largely lacking.

Yet without precise data -- linked to sharply-crystallized goals, techniques and long-range objectives -- the "field" of juvenile corrections can hardly be studied in a manner which will maximize chances for clarifying its relationship to mental health and other potential allies.

To partially remedy this deficiency, the task force developed a uniform reporting sheet for the use of District Courts and the Youth Services Division. This sheet is designed for electronic data processing. If its use becomes sufficiently developed, a wealth of information not presently available will accrue.

But present data -- including most used in this report -- are suggestive rather than definitive.

Three Levels of Control -- An Adaptation of the "Public Health" Approach:

In common with other aspects of mental health planning, this report seeks to consider delinquency services in terms of prevention, early detection and treatment, and rehabilitation of the failures. These correspond in rough degree to the classic public health levels of primary, secondary, and tertiary prevention. As adapted to the field of delinquency control, these levels become:

1) Prevention of delinquency from arising in the first place -- the task of society itself, its schools, churches, mores, etc.

2) Identifying and treating actual delinquents as early in their antisocial careers as feasible -- the task of police, courts, probation officers, and probably community mental health facilities.

3) Rehabilitating those who fail to respond to early treatment, the "hard core" or confirmed delinquents -- this is the task of the Youth Services Division with its two state institutions and its juvenile parole officers.

Note that if delinquency is defined as the sum total of all children referred to juvenile courts because of undesirable behavior, this public health format may be attacked. For referrals may be more a function of society reacting to the behavior of disadvantaged youth than a reflection of the outbreak of "disease" among individuals. Nevertheless, this scheme seems a useful way to examine the "treatment load" of identifiable delinquents and its relationship to mental health services.

I. Primary Prevention: Activities Designed to Prevent Delinquency From Occurring in the First Place

Specific activities which can be demonstrated to lower the incidence of delinquency are as rare in this field as in the field of mental illness. Success in reducing discrimination, social deprivation, poverty, and educational failures would probably lower the sum total of delinquency dramatically — but precisely how much is impossible to estimate. There is a frequently voiced belief that chances of becoming the official object of police action and court intervention are greatly increased for the poor and the disadvantaged. Similarly, it is believed by many that adolescent offenders from the middle class are less likely to be officially adjudicated and much less likely to be sent to a state institution. It is, in other words, quite likely that large numbers of middle class juvenile offenders fail to show up in official statistics. Keeping this possible skew in mind, an examination of data submitted on the new form by seven courts on all delinquents handled during a six week period in 1965[1] suggests that ethnic background plays a large role indeed in increasing the likelihood that a given child will become an official "delinquent". Of 403 delinquents in this sample, some 41% were Spanish-surnamed and 16% were Negro. For the state as a whole, only 9% of the population is Spanish-surnamed, and about 2% is Negro.

Denver is even more striking. Of 282 delinquents handled in this same six week period, 41% were Spanish-surnamed, 23% were Negro. The corresponding total populations for Denver are 9% Spanish and about 8% Negro. Most remarkable of all is Weld County where 41 of 56 delinquents were Spanish, a percentage of 73%![2]

But data on family income and school dropouts in this six week sample do not fully support some common stereotypes about delinquency. If "poverty" is defined as a family income below $3,000 a year, only 36% of 345 delinquents came from impoverished families. And only 22% were on public welfare ADC programs.

If $5,000 is made the cut-off point, the total increases to some 68%. Nevertheless, this leaves 32% of this delinquent population from families with incomes over $5,000 per year (and 14% over $7,000). Thus, the abolishment of poverty alone would not abolish — though it would doubtless greatly reduce — adjudicated delinquency.

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[1] The seven courts were Denver Juvenile Court, and District Courts 1 (Jefferson, Clear Creek, Gilpin Counties), 8 (Larimer and Jackson Counties, 13 (Morgan, Logan, Phillips, Sedgwick Counties), 18 (Arapahoe, Douglas, Elbert), 19 (Weld), and 20 (Boulder). Data was processed on IBM cards at Fort Logan Mental Health Center. The last half of March and all of April were included in this sample.

[2] Weld's total Spanish population is only 12%.

School dropouts are an even smaller factor in this sample than commonly believed. Only 16% of the total sample were not enrolled in school, and half of these had jobs. If the sample is restricted to those aged 16 and over (who are legally entitled to leave school), some 37% of the Denver delinquents were "dropouts" — but the number not only out of school but also without jobs was barely 19%.

Thus, merely reducing the school dropout rate (or "pushout" rate, as some sociologists prefer to define this process) would have many advantages -- but it might not reduce delinquency by such a drastic amount as some have predicted.

More promising might be efforts to ensure that each child had an adequate family life. Only 47% of these delinquents were living with both natural parents. For Negro delinquents, the percentage was even smaller: 34%. Only 54% of the parents were currently married. 34% were divorced or separated. 16% had lost a father or mother by death (extraordinarily high). And 4% were living with a parent or parents never married.

In summary, primary prevention of juvenile delinquency could be partially promoted by wiping out discrimination and reducing the impact of broken family life. It would also be aided -- but probably in much less measure — by reducing poverty in general and the number of school dropouts among adolescent youth. Neither correctional agencies nor mental health services are currently in a position to play any but minor roles in these fields. With adequate data (computerized by census tract, for instance) both could become major allies in assisting "War on Poverty" and civil rights agencies and urban renewal agencies, etc., to evaluate and sharpen the impact of their efforts.

II. Secondary Prevention: Early detection and treatment so as to reverse or control antisocial behavior as quickly as possible.

Although a host of agencies — including mental health clinics — attempt to ward off potential delinquency by identifying and treating the "pre-delinquent", society's principal reliance for handling major juvenile lawbreaking rests upon the juvenile court and its probation officers. One of the first juvenile courts founded in any city in the country is the Denver Juvenile Court, now with two full-time judges and 29 probation officers. In the rest of the state, juvenile offenders were handled by some 62 county courts until January, 1965. They are now handled by 21 District Courts.

Table I depicts the location of District Courts grouped by mental health planning regions.[3] Note that 14 of these courts have direct access to a mental

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[3]Districts 7 and 14 in Region 1 lap over by a single county into adjoining mental health regions. Similarly, District 5 in Region 5 includes a county from Region 1. District 4 includes all of Region 8 except for Cheyenne County which belongs to the 15th Judicial District. Compare the map of Judicial Districts (Appendix A) with that of Mental Health Planning Regions.

health clinic for all the counties within the court's jurisdiction. Seven courts can utilize local clinics for some counties only.[4] Only one District Court — the 15th, serving four counties in southeastern Colorado — has no access to any mental health clinic for any of its counties.

The number of full-time probation officers appears in the last column. Note that areas now comprising twelve judicial districts have no full-time probation officers. These twelve areas sent 143 delinquents to state institutions in the two year period covered in the data -- 18.7% or about one-fifth of the total (third column). One suggestion made to the Task Force was that mental health clinics offer consultation to those who serve as part-time probation officers in these areas.

This suggestion might be broadened. Such consultation -- amounting in some instances to informal case supervision where intrapsychic problems are manifest -- might be useful for many full-time probation officers as well. Of the 59 such officers in Colorado, only six have advanced training at the Master's level. Fifty-two have BA degrees and one is a high school graduate. Such men soon learn through experience much that is useful -- much, even, which might be new to mental health professionals. There would still appear to be a ripe area here for mental health consultation and in-service trainig efforts.

Incidentally, note from Table I that the five sub-regions comprising Region 11 — the Denver Metropolitan Area — sent 469 of the 763 juveniles to institutions as first commitments. This is 61% of the total, although Region 11 has only 55% of the state's total population. More striking, of 319 youths returned to the state's youth institutions in fiscal 1962-63, 241 or 76% were from Region 11. It would appear that half the state's population, concentrated in a vast urban complex, generates three-fourths of its major juvenile delinquents.

Referrals by courts to mental health facilities for diagnostic workups on delinquents are depicted in Table II. This two-year set of data is grouped by mental health regions rather than specific judicial district. The data for referrals to the Children's Diagnostic Center represent "hard" figures, gathered on a case by case basis. Referrals for reasons other than delinquency have been omitted. Here, referrals from Region 11 appear to be twice as frequent as from other parts of the state (78 children compared to 39 from Regions 1 through 10). It may appear ironic that the Denver area, with far more mental health resources available to it than outlying portions of the state, appears to lionize referrals of delinquents to the Children's Diagnostic Center. It is quite possible that this situation reflects the greater ease with which courts in Region 11 can utilize the Center rather than higher delinquency rates alone. Children from outlying counties must usually be boarded for several days in Denver (often at the State Children's Home) while their evaluation is taking place. This is a tiresome procedure. Combined with the need to make travel arrangements, it is yet another reason for couts utilizing local clinics when possible for diagnostic workups.

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[4] A clinic has just been organized to serve Garfield and Pitkin counties in District 9, leaving only Rio Blanco without access to clinic services.

Figures for court referrals to clinics (last column of Table II) are based on estimates supplied by these clinics. Present statistical forms used by clinics do not make it easy to tabulate referrals of "delinquents" as such. Nevertheless, it is possible to note that regions with strong clinics seem to send them six to ten times as many referrals as are sent to the Children's Diagnostic Center. Compare, for example, the ratios of clinic workups to CDC evaluations in regions 2, 3, 8, and 10, all of which are non-Denver areas with highly developed clinic services.

In general, clinic data can be interpreted as showing that about 220 to 250 delinquents are evaluated by mental health clinics each year, at the request of courts. This is about 10-12% of the child caseload of Colorado's clinics. What is more striking is that of this number, only 40-45 appear to be taken into treatment by these clinics. Thus, treated delinquent children represent only about 2% of the clinic's child treatment load. Or, one can say that only about one-fifth or one-sixth of those referred for evaluation by the courts are also engaged in therapy by the clinics.

Queried on this, some 8 clinics felt the delinquent is more difficult to treat than other children. Only 4 clinics felt work with delinquents was generally "as effective" as with non-delinquents. Lack of family cooperation, the "coercive element" inherent in a court referral, the tendency of the delinquent to "act out" his conflicts rather than develop internal anxiety over them, and similar causes were cited for such treatment difficulties.

Of 13 clinics replying to the questionnaire, 6 felt courts were making an appropriate number of referrals. Only 3 felt more referrals could be handled. Yet 10 of the 13 clinics felt they should somehow become "more involved" in serving the delinquent child. Consultation and inter-agency planning for multi-problem families were cited far more frequently as possible activities than either treatment or additional diagnostic workups. One clinic mentioned case supervision for inexperienced probation workers. Another frankly felt new demonstration projects should be initiated to better explore possible contributions by mental health clinics toward the problem of significantly reducing juvenile delinquency.

Table III and IV depict the outcomes of recommendations made to referring courts by the Children's Diagnostic Center. Note that about one-fifth of the time, the court refuses to follow CDC recommendations -- presumably in part due to local circumstances unknown to CDC but apparent to the responsible judge. About half the time, CDC recommendations are attempted but either the court cannot carry them out or the child fails to adapt to them. This was true for 53% of this sample (34% court failures, 19% child failures). The proportion of known outcomes which are unequivocally successful is slightly under one-third (27% in the sample).

Table IV shows the nature of these recommendations in more detail. It is apparent that referrals to a mental health clinic, a group living situation, or a residential treatment center are the most frequent recommendations. None are

conspicuously successful. This may in part be a reflection of the sheer lack of such facilities in many areas (particularly residential treatment centers). It probably reflects two other facets in addition: 1) the difficulty mental health clinics have in treating the "acting out" delinquent with conventional forms of psychotherapy (which rely on some degree of inner motivation toward change and internal anxiety); 2) the need for innovations and combined approaches (such as group therapy, deliberate use of the court's "authority" as a substitute for inner motivation, use of indigenous non-professionals from the delinquent's own cultural group, etc.).

The problem of cultural group, membership by many delinquents in a peer group in which anti-socail acts are "normal" rather than products of intra-psychic conflicts, and other sociological aspects of delinquency control are raised by data such as that in Table V. Here the percentages of youth with Spanish surnames committed to the two state rehabilitation institutions are compared to those referred to two sources of psychological evaluations. Roughly half of the males sent to Lookout Mountain School are Spanish surnamed. About a third of the girls sent to the Mount View School are likewise Spanish surnamed. But only one-fifth of those referred to Children's Diagnostic Center have Spanish surnames. While not "significant" in a rigorously statistical sense[5], this suggests that children with Spanish surnames are referred to this mental health facility less often than one would expect. This could mean either that (A) there is a hidden bias in the referral process which seeks more definitive answers for non-Spanish than for Spanish children who come to court; or (B) these children are correctly perceived to come from a milieu in which their problems are more socially derived than a product of intrapsychic conflicts. Hence, perhaps no need would exist for mental health evaluations.

It would appear that far more rigorous studies are in order to explore the possible differential use of mental health facilities by courts and other agencies on a basis of ethnic background.

III. Tertiary Prevention: Rehabilitation of those who fail to respond to early detection, treatment, and/or probation.

"Tertiary prevention" of juvenile delinquency in Colorado is primarily the function of Youth Services Division of the Department of Institutions. Lookout Mountain School for Boys, Mount View Girls' School, and Juvenile Parole are its principal facilities and services.[6]

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[5]Since data by sex are not available for CDC referrals in this study, the data for both state institutions must be combined for a chi-square test. The result, a chi-square value of 2.35, is significant only at the .20 level. Were the data restricted to males only, there is good reason to believe a highly significant chi-square value would emerge.

[6]Some youthful offenders go to the State Reformatory or even the State Penitentiary, however. In a sense, these are the most profound "failures" of all.

Lookout Mountain School for Boys, handling over 1,100 youths per year, has a 1/5 time consulting psychiatrist and a position (never filled) for a PhD clinical psychologist. On a full-time basis, it has a social service director with an MA in psychology and 5 rehabilitation counselors with BA degrees. Emphasis is upon counseling, vocational training, and remedial education. Psychologic and psychiatric time is largely devoted to evaluations and case consultation. There is often voiced a belief that the length of time boys are present is too short (4.9 months in 1960, 3.4 months in 1964). for major treatment effectiveness. However, a study of 60 boys paroled in June and July, 1965, revealed an average stay of 6 months -- thus reversing, at least for a time, a trend toward shorter and shorter stays that has gone on for the past five years. This may make a perceptible change in the revocation rates, and should be researched.

In addition, studies of the effect of increasing professional staff in 1960 as compared to 1955 suggest that even modest increases in staff time significantly reduce the number of "repeaters". Similarly, additional staff time to devote to detailed planning for parole significantly correlated with later success on parole.[7]

During a seven month period (June 1 -- December 31, 1962), some 26 boys were referred to the consulting psychiatrist. 14 had personality disorders of various kinds, 4 were psychotic or neurotic, 2 had immature personalities, 2 had organic impairment, 4 were of uncertain diagnoses. But these cases were from an institution handling over 1,100 boys a year (or about 670 in a seven month period). So this sampling of psychiatric problems is too small to tell much about the total population.

Table VI depicts diagnostic labels for three sample years at the Mount View Girls' School. Despite much questioning of the value of a psychiatric label in treating delinquents, it is remarkable what a high proportion of these major offenders seem to present identifiable psychological problems when diagnosed by mental health techniques.

These girls are handled by a staff which includes a professionally trained social worker (MSW degree), PhD psychologist (recently resigned, however), two rehabilitation counselors with BA degrees, and a part-time consulting psychiatrist (4 hours a week). Considerable amounts of group therapy are used. About 13 girls in each of the past two years were transferred to the State Hospital for major emotional problems.

One cannot review the size of these treatment staffs without feeling that they are far too small to promote major mental health programs. The amount of psychiatric consultation alone, is as noted in a report to the legislature this year, "obviously inadequate" and even "ludicrous".[8]

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[7]Hughes, Robert H., Unpublished Master's Thesis, University of Colorado, 1962.

[8]Budgetary requests, Division of Psychiatric Services, Department of Institutions, for fiscal year 1965-66.

Hence, it is not yet possible to really evaluate the contributions which mental health professionals might make to a total treatment program. While therapeutic techniques developed for well-motivated patients in traditional child guidance clinics are not often very useful when applied to the "hard core" delinquent, mental health techniques are not static. New departures in the treatment of "hard core" mental illness have been developed in recent years with remarkable success. New infusions of knowledge from such fields as sociology, anthropology, even political science are changing much of the emphasis in mental health theory and treatment techniques.

If ways can be found to enable courts, probation officers, police, etc., to establish viable working arrangements with local mental health practitioners, there is every reason to believe useful techniques might be developed in concert. Similarly, flexible use of imaginative mental health professionals in rehabilitation institutions -- for program development, case management consultation, and even supervision of some aspects of direct therapy and daily living arrangements-- would probably result in major additions to man's knowledge of how to increase the capacity of even the hard core delinquent to manage his life with some profit to society and himself.

TABLE I: Location of District Courts by Mental Health Regions — Probation Officers — Access to Mental Health Clinics

Mental Health Region	District Court	Commitments Lookout Mt. School*	Access to clinic in all Counties	Access to Clinic for some Counties Only	No Access to Clinics	Number full-time Probation Officers
	7	13		X		None
	9	7		X		None
1	14	0		X		None
	21	17	X			1
	6	18	X			None
2	22	9	X			None
3	8	16		X		1
4	19	25	X			1
	5	2		X		None
5	11	8		X		None
6	12	19	X			None
7	13	21	X			None
8	4	50		X		8
9	15	8			X	None
	16	17	X			None
	3	21	X			None
10	10	43	X			5
Region 11:						
Denver	2	349	X			29
Adams	17	41	X			6
Arapahoe	18	27	X			2
Jefferson	1	37	X			3
Boulder	20	15	X			3
Total		763*	14	6	2	59

* These commitments are totals from counties now served by the 22 District Courts. They were actually made, of course, by county courts in the two fiscal years 1962-63 and 1963-64.

Note: Region 11 = 469 or 61% of state total. Returnees in 1962-63 = 319 total; Region 11 returnees = 241 or 76%.

TABLE II: Referrals by Courts to Mental Health Facilities For Diagnostic Evaluations of Juvenile Delinquents: Two Year Period (1963 and 1964)

Note: Children's Diagnostic Center - actual figures.
Clinic data - based on estimates supplied by clinics.

Regions	Children's Diagnostic Center	Court's Own Mental Health Services	Local Mental Health Clinics
Region 1	12		2
2	1		6
3	3		42
4	1		*
5	1		*
6	4		*
7	2		*
8	10	?	80
9	3		2
10	2		42
Region 11:			
Denver	38	115	14[b]
Adams	10		*
Arapahoe	5		20
Jefferson	23		44
Boulder	0	?	*
Total For Region 11	78[a]		
Regions 1-10	39		
TOTAL	117	115[d]	252

Probable Total, All Mental Health Clinics -500[c]

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[a]Includes two from Grand County.

[b]Only one clinic out of three reporting.

[c]The 252 reported cases are from clinics seeing 49% of the total clinic patients in the state. Hence, assumption is that all clinics saw approximately 500 delinquents.

[d]Data available only from Denver. Two question marks (and possibly others) have some services.

TABLE III: Outcome of Recommendations Made by Children's Diagnostic Center to Referring Courts (1963, 1964).

	Number	Percentage of Known Outcomes
Court followed Recommendation:		
Successful Outcome	27	27%
Court followed Recommendation:		
Child Failed	19	19
Court Attempted to follow Recommendation:		
Failed*	34	34
Court Refused to follow Recommendation	19	19
Total Where Outcome is Known	99	100%
Results Unknown	18	
Grand Total	117	

* Due to lack of resources, refusal of agencies to accept case, too expensive, etc.

TABLE IV: Detailed Recommendations by Children's Diagnostic Center to Referring Courts: And Outcome (1963, 1964)

CDC Recommendation	Total	Successful Outcome	Child Failed	Court Attempted Recommendation: Failed	Court Refused Recommendation
Probation Only	1		1		
Mental Health Clinic	28	6	8	9	5
Special Ed. and Casework	2	1		1	
Foster Home Placement	5	2		1	2
Change Parental Custody	2	1	1		
Adoption	1	1			
Casework: Welfare	2				2
Group Living Situation	25	5	5	10	5
Residential Treatment Center	10	2	1	6	1
Colo. Children's Home	8	6	1		1
Colo. State Hospital	4	1		2	1
Training School (Retardation)	5			5	
State Correctional Institutions	6	2	2		2
Total	99	27	19	34	19
Unknown:	18				

TABLE V: Percent Spanish Surname Referrals* to Various Services: Two Year Periods

	Spanish Surname		Anglo, Negro and Other		
	No.	%	No.	%	Total
Denver Juvenile Court: Psychological Evaluations[1]	38	33%	77	67%	115
Children's Diagnostic Center[1]	25	21	92	79	117
Lookout Mountain School - New Admissions[2]	375	49	391	51	766
Mount View School for Girls[2]	93	32	200	68	293

Note: Spanish-surnamed population in both Denver and Colorado as a whole is approximately 9%.

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[1] Calendar years 1963 and 1964.

[2] Fiscal years 1962-63 and 1963-64.

TABLE VI: Diagnoses of Girls Sent to Mount View School During three recent years: (Table is in percentages)*

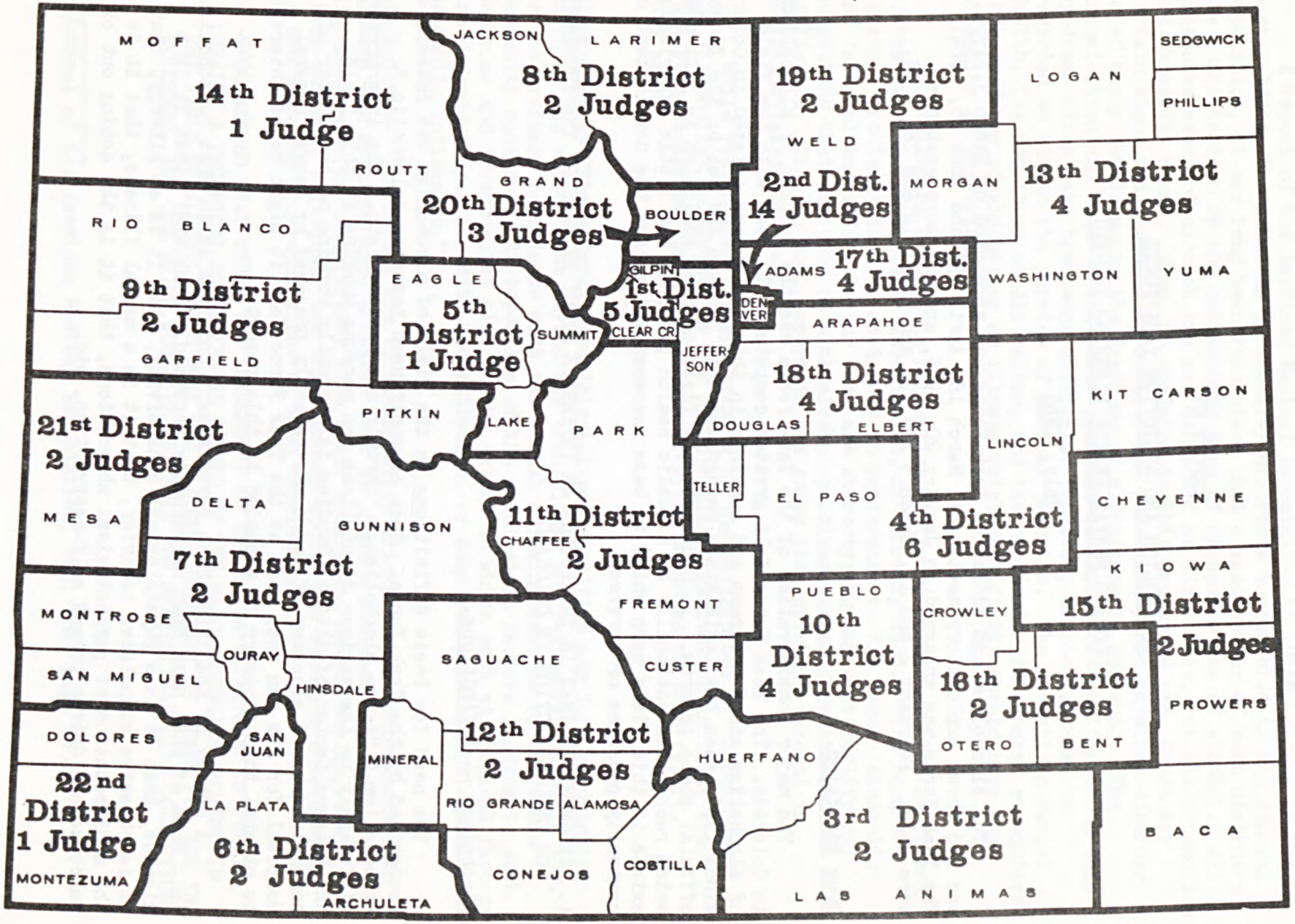
	1959 - 60	1961 - 62	1963 - 64
Adolescent Adjustment Reaction	6%	13%	11%
Neurosis	8	7	14**
Psychosis	11	7	21**
Character Disorder	11	14	6
Personality Disorder	7	18	25
Organic	7	6	11
Normal - or none given	51	35	13

* See Mount View Girls School, Report and Statistical Analysis, 1954-64 (Division of Youth Services, Department of Institutions).

** The abrupt increase in neuroses and psychoses in 1963-64 is probably a reflection of changes in testing procedures rather than the population of girls.

JUDICIAL DISTRICTS OF COLORADO

EFFECTIVE JANUARY 12, 1965



NOTE: Each of the four districts (1st, 8th, 17th, and 18th) will receive an additional judge in January 1969---to be elected at the 1968 general election.

Prepared by State Planning Division
May 1964

REPORT OF

ALCOHOLISM AND ADDICTION TASK FORCE

COLORADO MENTAL HEALTH PLANNING PROJECT

July, 1965

The Alcoholism and Addiction Task Force was appointed on March 3, 1964, and had three exploratory meetings: March 18, April 23, and June 25, 1964. The Task Force was enlarged on January 20, 1965, and six more meetings were held: February 2 and 17, March 3 and 17, and April 14 and 28, 1965.

Drug Addiction.

The major consideration of the Task Force was the problem of alcoholism in Colorado. The Task Force felt greater competence to deal with the field of alcoholism since programs and services in this field have existed in Colorado since 1949, when the Legislature recognized this problem and set up the first official state program. In contrast, the field of drug addiction is just now being recognized nationally as a public health problem, and little experience exists in this field upon which to base recommendations for the development of community programs or services.

1. RECOMMENDED THAT IN THE FUTURE AN INTENSIVE STUDY BE MADE OF THE PROBLEMS OF DRUG ADDICTION IN COLORADO.

Alcoholism -- Definitions.

The need for basic definitions in the field of alcoholism was immediately recognized by the Task Force. Such commonly used terms as "alcoholic," "alcoholism," "acute alcoholism," "chronic alcoholism," etc., are interpreted differently by the various disciplines and persons working in this field. The Rutgers Center of Alcohol Studies is currently working on the matter of nomenclature. A glossary of terms was recently prepared by Denver General Hospital for its own use, and, as the Task Force felt it might be of interest to others, this glossary is appended to this report.

A survey of the literature reveals many opinions as to what "alcoholism" is. None of them have been universally accepted. Some are: that it is a disease, that it is a physiological sensitivity, that it is an allergy, that it is obsessive compulsive behavior, that it is a mental illness, that it is the manifestation of psychological aberrations, that it is the acting out of subconscious drives toward self-destruction, etc.

A report of the American Medical Association in 1956*, states in part: "Among the numerous personality disorders encountered in the general population, it has long been recognized that a vast number of such disorders are characterized by the outstanding sign of excessive use of alcohol. All excessive users of alcohol are not diagnosed as alcoholics, but all alcoholics are excessive users. When, in addition to this excessive use, there are certain signs and symptoms of behavioral, personality and physical disorder or of their development, the syndrome of alcoholism is achieved. The intoxication and some of the other possible complications manifested in this syndrome often make treatment difficult. However, alcoholism must be regarded as within the purview of medical practice. The Council on Mental Health, its Committee on Alcoholism, and the profession in general recognizes this syndrome of alcoholism as illness which justifiably should have the attention of physicians."

The following appears in a Position Statement Authorized by the Council of the American Psychiatric Association, in February 1965: "The term 'alcohol problems' is used advisedly in preference to the terms 'alcoholic' and 'alcoholism' which, in our view are stereotyping and oversimplifying, suggesting that all persons with alcohol problems suffer from the same affliction. They do not, except in the sense that drinking alcohol is contraindicated for them."

While recognizing the shortcoming of the definitions of "alcoholism" and "alcoholic" as adopted by the World Health Organization in 1951, the Task Force accepted these definitions for the purposes of this report. They are:

Alcoholism -- "The general term 'alcoholism' signifies any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influences."

Alcoholic -- "Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal relations, and their smooth social and economic functioning; or who show the prodromal signs of such development . . . ."

2. RECOMMENDED THAT UNDER THE LEADERSHIP OF THE STATE DEPARTMENT OF PUBLIC HEALTH A TECHNICAL COMMITTEE BE FORMED OF THE MAJOR AGENCIES ENGAGED IN THE FIELD OF ALCOHOLISM TO WORK OUT A COMMON GLOSSARY OF TERMS FOR USE IN COLORADO, AND ONE WHICH WOULD BE SUITABLE FOR STATISTICAL DATA COLLECTION.

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* Journal of the American Medical Association, Vol. 162, page 750.

The Role of Mental Health

Special consideration was given to the question of the role which mental health should play in the development of alcoholism programs and services.

While the Task Force could not resolve the question as to whether alcoholism is basically a responsibility of mental health or of physical medicine, it was recognized by all committee members that there are many cases of individual alcoholics who drink secondarily to basic emotional problems of a well definable nature. Chronic depressive states, anxiety states, phobia and psychotic disorders serve as examples. Although present knowledge is inadequate, it is, nevertheless, evident that community mental health services should be fully utilized for diagnostic work-ups and -- where feasible on the basis of both evaluation and patient motivation -- as a therapeutic resource.

It was also recognized that mental health personnel have not in all cases assumed their full share of the responsibility in working with the problems of the alcoholic and his family, partly because the alcoholic is often a difficult and "unsatisfactory" patient, and partly because of the alcoholic's general reluctance to admit that he might have a need for mental health services.

3. RECOMMENDED THAT MENTAL HEALTH PERSONNEL SHOULD BOTH STUDY IN MUCH GREATER DETAIL THE POSSIBILITIES WHICH EXIST FOR RENDERING EFFECTIVE HELP TO CERTAIN ALCOHOLICS AND/OR THEIR FAMILIES, AND THAT THEY SHOULD BECOME ACTIVE PARTICIPANTS IN THE PLANNING FOR AND DEVELOPMENT OF COMMUNITY ALCOHOLISM SERVICES.

Extent of Problem.

The question of the size and extent of the problem of alcoholism in Colorado was reviewed. It was pointed out that a preliminary survey of the problem was made by the Colorado Commission on Alcoholism in 1949.

Information is being gathered for an up-to-date report which the State Department of Public Health is publishing this summer, "Alcoholism and Use of Alcohol in Colorado." This report will include mortality figures, prevalence estimates, arrests for drunkenness, admissions to treatment programs, motor vehicle accidents related to the use of alcohol, figures on the sale of alcoholic beverages, etc.

Information on alcoholism was gathered during the State Mental Health Planning Project. On April 5, 1965, the staffs of the Mental Health Planning Project and the Department of Public Health met and pooled collected information.

According to estimates based on the Jellinek Formula*, there are between 4½ and 6 million "alcoholics" in the United States. Each "alcoholic" is considered to affect in some way the lives of at least four other persons. Less than 1/10 are considered to be so-called "skid row drunks". Approximately 1/5 to 1/3 of all "alcoholics" are thought to be women. The cost of alcoholism to the nation is set at anywhere from one to two billion dollars a year.

Based on Jellinek Formula estimates, Colorado ranked 20th in 1960 in relationship to other states in the number of "alcoholics" per 100,000 population. Using a 1959-1963 average, it is estimated that there are approximately 52,000 persons in this state for whom the use of alcohol presents a serious problem. If to this figure is added the number of persons affected by these "alcoholics", there are more than 250,000 people affected, or 1/8 of Colorado's total population.

In addition to gathering basic statistics, the Task Force felt that certain more detailed studies might be made, such as an incidence study in one community — either a count of cases which seek help from various sources or through the establishment of a case register. The committee felt that such a register might be an appropriate function of out-patient alcoholism clinic, or a community alcoholism coordinator (see later discussion). It was further suggested that public health nurses might be asked to report on a state-wide basis how many cases now being seen involve an alcoholic in the family. Hopefully, one can expect that other caretaking agencies would be involved in similar studies.

It was further noted that detailed studies are now being made by the Fort Logan Mental Health Center and by Denver General Hospital which will provide valuable material in gaining a further understanding of the nature of the problem of alcoholism in Colorado. Also the State Department of Public Health is receiving a grant from the National Institute of Mental Health on June 1, 1965, "Development of Alcoholism Services in Public Health". One phase of this report will be a five-year fact gathering study to determine the needs of patients, families and communities in Colorado.

4. RECOMMENDED THAT INTENSIVE EFFORTS BE MADE TO DEVELOP A SYSTEMATIC COLLECTION OF DATA IN THE FIELD OF ALCOHOLISM IN COLORADO AND THAT AN INTERAGENCY COMMITTEE BE ESTABLISHED BY THE STATE DEPARTMENT OF PUBLIC HEALTH FOR THIS PURPOSE.

5. FURTHER, RECOMMENDED THAT A PILOT STUDY OF INCIDENCE AND/OR PREVALENCE BE UNDERTAKEN IN A SINGLE COUNTY IN COLORADO.

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*The Jellinek Formula, based on reported deaths from cirrhosis of the liver, is generally offered as a measure of the prevalence of alcoholism in a given population, but has never been tested for validity.

Resources Available.

The Task Force reviewed the services and resources currently available to the alcoholic, his family and the community in Colorado on both a state and local level. Reference was made to an inventory made by the State Department of Public Health, "Facilities and Resources in Colorado for the Alcoholic and the Family". Copies of the report are available to all professional persons in Colorado upon request.

The inventory lists two state treatment programs (Pueblo State Hospital and Fort Logan Mental Health Center), three half-way houses (two in Denver, one in Grand Junction), emergency services at Denver and Colorado General Hospitals, three community psychiatric hospitals, the Federal hospitals (Fitzsimmons General Hospital and three Veterans Administration Hospitals), seven shelter programs in Denver and Colorado Springs, most local health departments and county public health nurses, the five local councils on alcoholism, some (but not all) community mental health clinics, county departments of public welfare, Alcoholics Anonymous and Al-Anon in all larger communities, and eight voluntary health and welfare agencies. Other additional facilities and programs are in the planning stage, such as local community half-way houses, etc.

Criteria for Evaluating Alcoholism Services on the Community Level.

The Task Force attempted to set up minimum criteria for evaluating local alcoholism services, which criteria it felt might be useful to the Regional Planning Committees established as a part of the Mental Health Planning Project and to others working in this field. The questions were asked: What sort of resources should a local committee look for — or plan toward — for alcoholism? If a community really had a full range of facilities for the alcoholic, what would these ideally be?

Two charts were formulated. The first chart was designed to show what services, ideally, one would hope to find in a local community or what services should be available to a community. The second chart was designed to list the agencies, groups or persons which might provide these services.

COPIES OF THESE TWO CHARTS TITLED "COMMUNITY-LEVEL CONTROL OF ALCOHOLISM" FOLLOW ON THE NEXT TWO PAGES.

CHART I: IDEALIZED RANGE OF SERVICES
CHART II: AGENCIES WHICH MIGHT PROVIDE SERVICES

The Committee felt that local communities might match the services suggested in these charts with what is presently available in their community. It was noted that not all communities could expect to have every needed service in their own area — some services would not be feasible on the local level but should be available on a regional or state level.

Responsibilities of Official State Departments.

The Task Force recognized that two state departments are charged by law with specific responsibilities in the control and prevention of alcoholism. In addition, other departments provide services which relate, directly or indirectly, to the welfare or rehabilitation of either the alcoholic or his family, to problems connected with the use of alcohol, or to educational programs such as in the public schools.

The Department of Public Health is officially responsible for the study of the problem of alcoholism in Colorado, for professional and public education in alcoholism, and for the development of community public health services for the alcoholic and the family. This latter includes case finding, counseling and referral, public health nursing, follow-up, and community education, including efforts toward prevention.

The Department of Institutions provides certain treatment services in alcoholism. The Alcoholic Treatment Center at the Colorado State Hospital and the Alcoholism Treatment Division at Fort Logan Mental Health Center treat alcoholics in large numbers. Theoretically, these are "second echelon" facilities serving patients who have failed to respond to community resources. In addition, some state-aided Community Mental Health Clinics are seeing alcoholics and/or their families.

Other departments which have a concern for the problems of alcoholism or the inappropriate use of alcohol are the Departments of Rehabilitation, Public Welfare, Education, and Employment; and the Divisions of Adult Parole (Institutions), Motor Vehicles (Revenue), Liquor (Department of State), Corrections (Institutions), the State Patrol, Highway Safety Control Council, etc.

Three issues were noted: (1) that there is no one state agency with a clear cut, overall responsibility for the problem; (2) that there is a need for closer working relationships between all state-level departments concerned; and (3) that areas of department responsibilities need to be clarified in the development or extension of needed programs or services.

6. RECOMMENDED THAT THE STATE DEPARTMENT OF PUBLIC HEALTH TAKE THE LEADERSHIP IN BRINGING TOGETHER THE OFFICIAL STATE DEPARTMENTS CONCERNED WITH THE PROBLEM OF ALCOHOLISM IN COLORADO IN ORDER TO STIMULATE COORDINATED PROGRAM PLANNING AND A CONTINUOUS REVIEW OF PROGRAMS AND PROBLEMS IN THIS FIELD.

Leadership for the Development of Local Services.

The question was then raised: Where does or should leadership exist on the local level for the development of community services in alcoholism? The following groups and agencies were mentioned: local medical societies, health departments, community mental health clinics, councils on alcoholism, welfare departments, social agencies, etc. Also: Which state agencies should take the leadership in stimulating the development of local services, and what [illegible] the line of demarcation between state governmental and local governmental (both county and municipal) responsibilities?

CHART I: COMMUNITY-LEVEL CONTROL OF ALCOHOLISM - AN IDEALIZED RANGE OF SERVICES

	Prevention	Early Identification	Evaluation & Diagnosis	Treatment	Rehabilitation	Follow-Up
Individual	1. Education: General Public	1. Community Case Finding 2. Referral to proper resources 3. Coordinating Device (assumption of leadership for each case so as to assure continuity of care throughout treatment and follow-up).	1. Medical 2. Psychiatric 3. Social	Acute or Short-Term: 1. Medical management of physical crises - D.T.'s, etc. 2. Counseling and emotional support 3. Protective custody if needed Chronic or Long-Term: 1. Medical management 2. Psychotherapy 3. Group therapy 4. Casework 5. AA	1. Vocational counseling 2. Housing 3. Employment 4. Continued therapy as needed	1. Availability of continued counseling, etc., as needed. 2. Continuation of coordinating devices 3. Long-term custodial care where necessary
Family	2. Education of key helping professions	1. Community Case Finding (Families with members who have drinking problems) 2. Referral (Non-drinking members seeking help) 3. Coordinating device as above (esp. for multi-problem families)	Case Work: psycho-social, family-oriented diagnosis	1. Counseling 2. Psychotherapy 3. Group therapy 4. Family therapy 5. Alanon & Alateen 6. Financial support where necessary	1. Counseling 2. Social agency assistance 3. Financial support	
Community	1. Detection of Problem areas: Ethnic groups, work situations and other environmental factors; community attitudes, etc. 2. Epidemiological studies. 3. Social research, etc.			Community Change Through: 1. Social Action 2. Legislation 3. Creation of needed facilities 4. Program evaluation		

CHART II: COMMUNITY-LEVEL CONTROL OF ALCOHOLISM - AGENCIES WHICH MIGHT PROVIDE SERVICES

	Prevention	Early Identification	Evaluation & Diagnosis	Treatment	Rehabilitation	Follow-Up
Individual	1. Education - General Public: a. Health Dept. b. Local Alcoholism Councils c. Schools d. Information Center e. Mass Media f. Church 2. Education - Key Helping Professions:	1. Family Physician 2. Health Department 3. Local Alcoholism Councils 4. Public Welfare 5. Voluntary Social Agencies 6. Mental Health Centers 7. Courts and Police 8. Industry 9. Clergy	1. Family Physician 2. Psychiatrist 3. Gen. Hospital 4. Health Dept. 5. Mental Health Centers	Acute: 1. General Hospital 2. Private Psychiatric Hosp. 3. Physician - - - - - - - - - - - - - - - Chronic: 1. Private Psychiatric Hosp. 2. Physician or psychiatrist 3. State Facilities: Ft. Logan, State Hospital 4. A.A. 5. Supportive Groups (such as Salvation Army, Citizens' Mission, etc.)	1. Vocational Rehab. 2. Halfway Houses 3. After-care Programs (public health, welfare, mental health) 4. Employment Service 5. Continued medical care 6. A.A. 7. Supportive Groups	Long-Term Custodial Care for Permanently Damaged? 1. Physician 2. Clergy 3. Community Counseling Agencies 4. A.A.
Family	a. Health Depts. b. Local Alcoholism Councils c. Mental Health Centers d. State Agencies e. Universities	Coordinating Device (any of above Agencies) →		1. Family physician and/or psychiatrist 2. Clergy 3. Al-Anon and Alateen 4. Family Service and Other Social Agencies 5. Health Departments 6. Community Mental Health Centers 7. Welfare Departments 8. State Facilities - Fort Logan and State Hospital		
Community		1. Individual Agencies (Health, Welfare, etc.) 2. Planning Councils (if available) 3. Civic Groups 4. Local Government planning staff 5. Universities & other research centers 6. State Agencies		1. Legislature 2. County Commissioners 3. City Councils 4. United Fund and other citizen action groups (including industries)		

It was noted that the Alcoholism Division of the Fort Logan Mental Health Center has worked closely with a few local communities in Colorado in stimulating the development of after-care programs for alcoholics who have been treated at Fort Logan. The State Department of Public Health is working with both local health departments and local councils on alcoholism in the development of community educational, case-finding, counseling, and follow-up services. Community mental health clinics are seeing some alcoholic patients and families. Some local medical societies have committees on alcoholism and/or addiction.

It was further noted that the Department of Public Health project, "Development of Alcoholism Services in Public Health," which project is endorsed by the State Department of Institutions (the Mental Health Authority in Colorado), provides for pilot demonstrations in ways in which community services in alcoholism can be developed for patients and families. When implemented, these demonstrations will involve many local agencies and resources as well as the state-level agencies concerned.

7. RECOMMENDED THAT THE STATE DEPARTMENT OF PUBLIC HEALTH TAKE LEADERSHIP IN STIMULATING THE DEVELOPMENT OF ADEQUATE COMMUNITY PROGRAMS AND SERVICES IN ALCOHOLISM IN LOCAL HEALTH DEPARTMENTS, LOCAL COUNCILS ON ALCOHOLISM AND OTHER APPROPRIATE COMMUNITY AGENCIES.

8. RECOMMENDED THAT THE STATE DEPARTMENT OF INSTITUTIONS ENCOURAGE COMMUNITY MENTAL HEALTH CLINICS AND THE PROPOSED COMPREHENSIVE MENTAL HEALTH CENTERS TO PLAY A VITAL ROLE IN PROVIDING BOTH DIRECT SERVICES AND CONSULTATION TO THE COMMUNITY AGENCIES SERVING THE ALCOHOLIC.

Continuity of Care.

In preparing Chart I, "An Idealized Range of Services," the Task Force immediately recognized the need for some device to insure continuity of patient care for those persons turning to community resources for help with an alcoholism problem. This continuity is needed from the time the alcoholic or family members first comes to a community agency through the follow-up period, since generally in a single case a number of community resources and agencies are involved. It was pointed out that much of the problem of alcoholism lies in the family area, and the family situation needs as much attention as that of the alcoholic.

A method for providing for the continuity of care is suggested in the project, "Development of Alcoholism Services in Public Health." As proposed in this project, an out-patient alcoholism clinic would be developed by a local health department on a demonstration basis. This clinic would serve as a screening and referral center, provide patient evaluation, diagnosis, counseling, and case follow-up, and would also serve as a focus for community education. The clinic would fully utilize all community resources such as private physicians, state treatment programs, community mental health clinics, public health nursing services, Alcoholics Anonymous and Al-Anon, welfare and rehabilitation department services, social agencies, the clergy, etc. Under medical direction, the clinic would be staffed by trained professional personnel such as social workers and public health nurses and utilize the psychiatric and psychological consultation services of the community mental health clinic.

In two smaller population areas of the state the project also provides for the addition of one professionally trained staff member in a local health department, which person would work to coordinate services for alcoholics and their families using all available community and state resources.

9. RECOMMENDED THAT THE EXPERIENCE GAINED FROM THE PROJECT "DEVELOPMENT OF ALCOHOLISM SERVICES IN PUBLIC HEALTH," BE STUDIED AND EVALUATED IN ORDER TO CLARIFY THE SPECIFIC ROLES OF LOCAL HEALTH DEPARTMENTS, COMMUNITY MENTAL HEALTH CLINICS AND OTHER KEY COMMUNITY AGENCIES AND RESOURCES, AND PRIOR TO THE ESTABLISHMENT OF A STATE-WIDE SYSTEM OF COMMUNITY BASED ALCOHOLISM SERVICES.

Admission of Patients to Private Hospitals.

The Task Force felt that the criteria for admission of alcoholics to a general hospital should be identical to the criteria governing admission of other patient groups and where appropriate special therapeutic programs should be developed for this group. It was felt that all general hospitals in Colorado should be urged to take steps which would allow them to open their doors to alcoholics just as they do to any other acutely ill patients; that alcoholics should be admitted under the diagnosis of alcoholism; and that hospital insurance plans which exclude payment for hospitalization for alcoholism should seriously consider coverage for this illness in their plans.

The 1956 statement of the Council on Mental Health of the American Medical Association* states in part: "The Council on Mental Health, therefore, urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic alcoholism should not be considered as an illness which bars admission to a hospital, but rather as qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency."

10. THE TASK FORCE ENDORSES THIS RECOMMENDATION OF THE AMERICAN MEDICAL ASSOCIATION AND URGES ITS GENERAL ACCEPTANCE.

Treatment Facilities.

The Task Force noted that Colorado lacks adequate facilities for the treatment of the alcoholic patient. It was stated that Fort Logan and the State Hospital cannot cover all of the treatment needs of the state. It was pointed out also that there are not enough community facilities for treating alcoholics, nor is enough being done in the field of follow-up management.

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* Journal of the American Medical Association, Vol. 162, Page 750.

The question was raised: Should the alcoholic be treated at the local level first? It was noted that the model of the State Mental Health Planning Committee is that the major range of services in mental health should be provided by the local community. Does this same philosophy seem right for alcoholism?

11. RECOMMENDED THAT THE MAJOR RANGE OF SERVICES FOR THE CARE OF THE ALCOHOLIC BE HANDLED IN EACH COMMUNITY BY THAT COMMUNITY AND THAT THE AFTERCARE SHOULD ALSO BE A COMMUNITY OPERATED PROGRAM; FURTHER, THAT THOSE WHO FAIL TO BENEFIT FROM COMMUNITY SERVICES OR THOSE WHO NEED ADDITIONAL OR SPECIALIZED SERVICES SHOULD BE REFERRED TO A STATE OPERATED TREATMENT PROGRAM UNTIL PROPOSED ADDITIONAL COMMUNITY SERVICES ARE ESTABLISHED.

12. FURTHER RECOMMENDED THAT THE CRITERIA FOR COMMUNITY CARE SHOULD BE DEFINED MORE SPECIFICALLY.

Need for "Drying Out" Facilities.

It was pointed out that while the alcoholic may require some medical care while he is "drying out," his needs may not require hospital admission, The indication for hospitalization should be based on sound medical judgment rather than on a desire to use the hospital merely as the machinery for removing the bottle from the patient even though this need (to stop the patient from drinking) is vital and may be the motivating factor for the alcoholic.

13. THE TASK FORCE BELIEVES THAT "DRYING OUT" FACILITIES ARE INADEQUATE IN MOST PARTS OF THE STATE AND RECOMMENDS THAT EFFORTS SHOULD BE MADE BY LOCAL COMMUNITIES TO MAKE SUCH FACILITIES MORE READILY AVAILABLE.

The Problem of the "Poorly Motivated" or "Terminal" Alcoholic.

It was pointed out that there is a "hard core" of alcoholic patients who are constant repeaters in treatment programs. For several reasons this group seems to lack motivation to get well. The question was asked: At what point should treatment be discontinued for such non-motivated patients?

It was suggested that there is a need for some type of protective environment for these persons which would provide shelter, warmth and food -- an area which would not expect but would not deny the opportunity for rehabilitation. Such a shelter type of program would be less costly to provide than the service now being provided by the treatment programs, and would free the treatment programs to serve other patients. The question was raised as to whether admission to such a facility should be by court commitment or on a voluntary basis only.

14. RECOMMENDED THAT THE AREA OF THE UNMOTIVATED ALCOHOLIC BE INVESTIGATED FURTHER AND THAT CONSIDERATION BE GIVEN TO THE POSSIBLE DEVELOPMENT OF SOME TYPE OF SUPERVISED LIVING PROGRAM.

15. FURTHER, RECOMMENDED THAT A STUDY BE MADE OF THE LACK OF MOTIVATION OF THE SO-CALLED "HARD CORE" ALCOHOLIC TO DETERMINE WHETHER OR NOT SUCH APPARENT LACK OF MOTIVATION IS IN FACT IRREVERSIBLE.

Early Identification.

The Task Force felt that all community agencies and professional persons dealing with the problems of families have a responsibility for the early identification of problems of alcoholism, and for referral. This immediately suggests that there needs to be in-service training programs on alcoholism for community agencies and other community groups. (It was pointed out that the problem of alcoholism involves the home, the school and the church.)

The NIMH Project, "Development of Alcoholism Services in Public Health," suggests the development of community "task forces for case-finding and case referral." Such a task force "would include key representatives of the clergy, courts, law enforcement, welfare, industry, etc." Public and professional education would be a part of such a program. Such a task force could be organized by an outpatient alcoholism clinic, a local health department, a local council on alcoholism, or a community alcoholism program coordinator attached to an appropriate agency.

It is generally recognized that schools have a responsibility for teaching "alcohol education" -- sound information about the use of the beverage alcohol and its effects on the body. Several states have personnel in state departments of instruction who work with teachers on the presentation of this subject in the classroom. Some of the school systems in Colorado have or are preparing teaching guides on alcohol education.

Since 1887 a Colorado law has required that the "effect of the use of alcohol" be taught in the public schools. Units of study and encouragement and development of courses by local school districts in Colorado is provided by the State Department of Public Health. Some of the school systems have or are preparing teaching guides on alcohol education, generally as a part of a unit on alcohol, smoking and narcotics.

16. RECOMMEND THAT THE STATE DEPARTMENT OF PUBLIC HEALTH ASSIST LOCAL COMMUNITIES TO DEVELOP PROGRAMS IN PUBLIC AND PROFESSIONAL EDUCATION WITH EMPHASIS ON EARLY CASE FINDING.

17. RECOMMENDED THAT THE SCHOOLS IN COLORADO BE ENCOURAGED TO DEVELOP PROGRAMS IN ALCOHOL EDUCATION.

Professional Education.

While professional educational institutes and programs in alcoholism have been conducted in Colorado ever since the funding of the Colorado Commission on Alcoholism in 1952, the Task Force discussed several areas in which it was felt that greater efforts are needed.

It was the observation of the Task Force that medical students and nurses in training generally — as well as residents in psychiatry— do not receive sufficient information pertinent to alcoholism, nor do other students of such professionals as social work, psychology, the law, the ministry, education, etc.

As to physician post-graduate education, the Medical School staff reported that it has found local physicians throughout the state eager to learn more about alcoholism and mental health problems and how to deal with their patients.

The Bureau of Continuation Education of the University of Colorado and the Department of Public Health are currently exploring the possibility of establishing a school or institute of alcohol studies in Colorado similar to the summer schools in Utah, New Mexico, Texas, North Dakota, and other states in the United States.

18. RECOMMENDED THAT THERE SHOULD BE BASIC PREPARATION IN THE FIELD OF ALCOHOLISM FOR THE STUDENT IN THE PROFESSIONS MOST CONCERNED WITH THIS PROBLEM AS WELL AS CONTINUED POST-GRADUATE EDUCATION.

19. THE TASK FORCE ENDORSED THE IDEA OF ESTABLISHING AN ANNUAL SUMMER SCHOOL OR INSTITUTE OF ALCOHOL STUDIES IN COLORADO.

20. THE TASK FORCE ENDORSED THE IDEA OF AN ANNUAL CONFERENCE OF ALL PERSONS WORKING IN THE FIELD OF ALCOHOLISM IN COLORADO IN ORDER TO PROMOTE COMMUNICATION AND UNDERSTANDING, AND URGES THE STATE DEPARTMENT OF PUBLIC HEALTH, IN COOPERATION WITH OTHER STATE AGENCIES, TO CONSIDER THE ORGANIZATION OF SUCH AN ANNUAL CONFERENCE.

Prevention.

The Task Force agreedthat the prevention of alcoholism is the ultimate goal. Some preventive measures, such as early intervention and education, have already been suggested. Also involved, however, is the ideal of preventing the onset of alcoholism by changing behavior patterns and attitudes.

The Task Force recognized the fact that preventive efforts in alcoholism are hampered at this time by a lack of definitive knowledge as to the exact factors, undoubtedly multiple, involved in the production of abnormal drinking behavior. (The many conflicting opinions as to what alcoholism is have already been discussed.) Since the etiology of alcoholism is not known, "prevention" now is really early treatment. The committee conjectured that "perhaps alcoholism is a disease of society".

Whatever the etiology of alcoholism, the Task Force concluded that the development of preventive programs in this field is the greatest need.

21. RECOMMENDED THAT A FUTURE GROUP STUDY MORE THOROUGHLY THE POSSIBILITIES OF DEVELOPING PROGRAMS FOR THE PREVENTION OF ALCOHOLISM IN COLORADO.

Continued Study of Problem.

The Task Force, in reviewing the preceding report of its work, recognized the need for continued study of the problem of alcoholism in Colorado. While it felt it had at least delineated the major problems in the field of alcoholism, it immediately recognized the fact that its work was far from complete.

The question of recommending the continuation of the present Task Force was considered. However, in view of the fact that the State Department of Public Health is officially charged with the responsibility for the study of the problem, the Task Force made the following recommendations:

22. RECOMMENDED THAT THE STATE DEPARTMENT OF PUBLIC HEALTH SET UP AN ON-GOING COMMITTEE FOR THE CONTINUED STUDY OF THE PROBLEM OF ALCOHOLISM IN COLORADO AND THAT THIS COMMITTEE INCLUDE SUITABLE REPRESENTATION FROM STATE AGENCIES AS WELL AS FROM KEY PROFESSIONAL GROUPS AND PROGRAMS, BOTH STATE AND LOCAL.

23. FURTHER, RECOMMENDED THAT THIS COMMITTEE BE CHARGED WITH THE RESPONSIBILITY OF IMPLEMENTING THE RECOMMENDATIONS OF THIS TASK FORCE AS SET FORTH IN THIS REPORT, AND OF EXPLORING THE BASIC PROBLEMS IN THE CONTROL OF ALCOHOLISM MORE DEEPLY.

Respectfully submitted,

Graydon Dorsch, Chairman
State Department of Public Health

Lester R. Bellwood, Ph.D., Th.D.
Fort Logan Mental Health Center

Stanley W. Boucher
State Department of Institutions

Ernest G. Ceriani, M. D.
Grand County Health Officer, Kremmling

Miss Jane Collins
Denver Dept. of Health and Hospitals

Edward J. Delehanty, M. D.
Addiction Committee
Colorado State Medical Society

Mrs. Bernice diSessa
State Department of Public Health

Russell Haase
State Department of Rehabilitation

Richard Jessor, Ph.D.
University of Colorado

John F. Kelly, M. D.
University of Colorado Medical Center

Mrs. Frona McCambridge
State Department of Public Health

Robert O'Haire
State Department of Public Health

Ray O'Neal
Division of Adult Parole,
State Department of Institutions

James Pierce
State Department of Public Health

Mrs. Ruth Pierce
State Department of Public Welfare

William M. Robinson, M. D.
Denver General Hospital

Charles Shearn, M. D.
Colorado State Hospital

Arthur Smith
Denver Area Council on Alcoholism

THE ECONOMIC COSTS OF MENTAL ILLNESS IN COLORADO: A Special Report

This report was produced by Steven Weiss, special economist for the Mental Health Planning Project. At the suggestion of Dr. R. A. Zubrow, Professor of Economics at the University of Colorado, no task force or committee was formed to delve into the economics of mental illness. Instead, it was felt wiser to place a single man alone in an office, surround him with piles of data and a calculator, and let him grapple with one of the most complex and least researched problems in public finance. Despite the enormous investment all states make in the operation of their public mental health programs, almost no literature has been developed whereby a state can examine total costs, direct and indirect, or make comparisons between its own operations and those of other states. Weiss was confronted by an unmarked field, a paucity of the precise data he needed, and mountains of inexact or irrelevant facts and figures. He also had to face boundless ignorance on the part of his new mental health colleagues regarding modern economics, its causes and its cures. Mr. Weiss's study was greatly facilitated by help and advice from Robert Denholm, Chief of Administrative Services of the Department of Institutions. Continual guidance and professional supervision came by Dr. Zubrow. Finally, Mrs. Dolores Renze, State Archivist, supplied office space in the State Archives Building — for which we are also most greatful.

SUMMARY:

I. The costs of mental illness in terms of suffering, demoralization of family life, stunting of career development, and similar effects cannot possibly be measured with present tools. Consider, for eample, the "costs" of a single suicide to a family which still has children to raise. On the other hand, the direct costs of operating public mental health resources can be documented. So too, to a degree, can the indirect costs to society be measured in terms of loss of productivity by those hospitalized for mental illness.

II. Direct Costs: Formal Mental Health Services

1. Colorado has maintained a leadership role in the west in its expenditures on public mental hospitals. Except for Alaska, it exceeds all other western states in expenditures per patient, cost per state resident, and cost per $1,000 of personal income.

2. On the other hand, its percentage increase since 1960 (32.2%) is less than the national average (38.9%).

3. Direct state expenditures for all mental health activities -- hospitals, clinics, alcoholism, vocational rehabilitation, child welfare for emotionally disturbed children, etc., are now $23.5 million.

4. Local community expenditures are $.5 million.

5. Three state facilities -- Fort Logan, Colorado State Hospital, and Colorado Psychopathic Hospital -- accounted for 94% of state expenditures for mental health in 1961. By 1965, they still accounted for 93%. First echelon care in local communities -- now mostly clinics - has received a slowly increasing, but still tiny, share of this total.

6. Proportionately, the state's general fund expenditures have increased much more since 1961 than its mental health expenditures. The general fund increased 92% from 1961 to 1965. Total mental health expenditures went up only 62%.

7. Thus, mental health expenditures declined as a percent of the general fund: from 15.4% in 1961 to 13.0% in 1965.

III. Indirect Costs: Loss of Earnings while Hospitalized

1. Using three different methods, a minimum estimate of income lost at Fort Logan, Colorado State Hospital, and the two VA Hospitals is about $14 million. (Figures apply to all patients admitted in one year.)

2. Loss of earnings for those treated in longer-stay hospitals is about six times that of those receiving the most intense treatment.

3. A male patient losses nearly $5,000 per year of hospitalization, or nearly $25,000 in five years. If discharged in 3 months, he has lost only about $1,200.

4. Though present data is still too crude for precise proof (cohort studies with suitable controls are needed) there is now further reason to belive that intensive care with heavy staff-patient ratios result in ultimate economic savings to a progressive state.

IV. Total Estimated Costs: Public Sector Mental Health Services

1. Direct expenditures totaled about $24 million in 1965.

2. Estimated indirect losses totaled $14 million in 1963. (a minimum estimate!).

3. Total costs for public mental health services only now run at least $38 million per year.

4. These estimates ignore losses undergone by those treated privately for mental illness. They ignore losses due to delinquency, most alcoholism, suicide, failure of individuals to reach maximum potential due to neuroses, etc.

5. Stronger first echelon services on the community level, treating more patients but intensively enough to secure rapid discharge, would be a wise economic investment for Colorado.

V. Future Data: Areas for Further Research

1. Uniform statistics — ideally, a "case register" — collecting comparable patient data from all public mental health services would enormously improved Colorado's capacity to submit its mental health program to continuing economic analysis.

2. Similarly, uniform application of modern cost accounting principles should be introduced into all state-operated and state-aided facilities. Until this is done, no relative costs of program content can be identified.

3. Finally, follow-up studies of patient cohorts -- with focus upon employment, income, and rehospitalization elsewhere — would enable direct costs of mental health services to be buttressed with far more accurate data on the indirect costs of mental illness.

THE ECONOMIC COSTS OF MENTAL ILLNESS IN COLORADO: A Special Report

(Submitted by Steven Weiss, Economist for the Mental Health Planning Project, 1964-65)

Introduction: Delineation of the Problem

The report attempts to document the economic costs of the public mental health program in the state of Colorado. When defining the economic cost of a mental health program, whether public or private, it is necessary to exclude the suffering of individuals and their families.[1] Thus, only that portion of the cost of mental health which is contained in public programs and can be estimated in dollar terms is included.

The scope of the study has been narrowed to include only formal mental health agencies in the public sector of the economy. This definition excludes many social problems which might be included under a broader definition of mental health -- for instance, crime, juvenile delinquency and most problems handled by social welfare agencies. In addition, it excludes the mentally ill not under care. The agencies included in the study are the nineteen community mental health clinics, the Colorado State Hospital, Fort Logan Mental Health Center, Colorado Psychopathic Hospital, two Veterans Administration Hospitals, the rehabilitation programs of the Colorado Department of Rehabilitation, and the Child Welfare Services.

Economic costs will be divided into direct and indirect.[2] Direct costs include the actual operating expenditures of mental health agencies (excluding capital construction). Indirect costs represent the economic loss to society caused by the loss of productivity of those members of society who are hospitalized for mental illness.

Direct costs of mental health then, are the actual use of public economic resources for the prevention, diagnosis, treatment and rehabilitation of mental illness. Direct expenditures for state and county mental

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[1] For a more detailed discussion of these considerations see Weisbrod, B. A. Economics of Public Health, (University of Pennsylvania Press, Philadelphia, 1961), p. 95-98.

[2] The following definitions of direct and indirect cost and their measurement were developed by Rashi Fein in Economics of Mental Illness, (Basic Books, Inc., New York, 1958).

hospitals will be compared between selected Western states[3] and Colorado for the years 1960 to 1964. Then State and local expenditures on the various formal public mental health agencies in Colorado will be presented and analyzed on a regional basis.[4]

Indirect costs -- the loss of earnings to the individual and of productivity to society -- are necessarily vague in nature. The question which has to be answered is what would the mentally ill have earned or produced if they had not suffered from mental illness. The detailed information necessary to compute estimates of what their economic contribution would be if they were healthy is available only for the Colorado State Hospital, Fort Logan Mental Health Center and Colorado residents who are mental patients at Veterans Administration hospitals.

Data from Colorado Psychopathic Hospital is excluded from the indirect calculations due to its special nature as a teaching hospital and the relatively short average length of stay of its patients. Also excluded are indirect costs attributable to patients treated by community mental health clinics. Clinic services are on an outpatient basis and such loss -- while not measurable at this time -- is presumably minimal. For the same reason, the length of stay statistics at Fort Logan Mental Health Center exclude time spent as outpatients.

Also excluded are the direct and indirect cost of private mental hospitals and psychiatric wards of general hospitals. Many other areas of indirect cost which could be attributable to mental illness are excluded primarily due to lack of data. Such costs include the extent of permanent and partial disability upon release from the hospital, much absenteeism and other disruption of work, the contribution made by the unpaid housewife, the mentally ill who are under private professional care, and the vast number of the mentally ill who do not seek professional care. Thus the total costs, direct and indirect, of the state program will understate the actual economic cost to the people of Colorado. Nor will this data measure the added burden of suffering borne by the mentally ill and their families.

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[3] The thirteen Western states consist of the mountain region (Arizona, Wyoming, Colorado, Idaho, Montana, New Mexico, Nevada and Utah) as well as the far western states of Alaska, California, Hawaii, Oregon and Washington.

[4] The regions used for this study are the eleven mental health planning regions developed in Colorado as part of its comprehensive planning project in 1963-65.

I. DIRECT COSTS

A. Interstate Comparisons:

Interstate comparisons of economic data may be misleading. Such data depend upon varying levels and rates of change of population, income, industrialization, urbanization and many other factors. When the comparisons are for a specific category of expenditure, such as mental health, the difficulties are compounded. Probably the most reliable data available are for state and county mental hospitals reported in Mental Health Statistics, Current Reports of the National Institute of Mental Health.

Nevertheless, there are still many problems of comparability even in these statistics. One major problem is varying price levels for basic costs of non-professional and professional care. A second is the different accounting procedures used by hospitals and for hospital-operated farms. A third more recent problem is the handling of fees charges to patients. Some states return fees to the general fund while others include them in operating funds, thereby lowering their apparent expenditures.

A more fundamental problem lies in the differences in purpose and function of hospitals. This problem is accentuated by the presence of "psychopathic hospitals" only in California and Colorado[5] among the Western states. Even among state hospitals per se, there are differences in admission, release and treatment policies which make any type of comparison extremely difficult. Fort Logan Mental Health Center, for instance, is unlike any other hospital in the West. The best method of overcoming this problem is the use of NIMH's expenditure per patient under treatment. Such patients are defined as those in treatment at the beginning of the year plus all admissions during the year excluding transfers.

A final difficulty arises with capital expenditures. One aspect of this problem is different accounting techniques for allocating various expenditures for patient maintenance or maintenance of the physical plant. The problem becomes more acute when major capital construction is considered. Since capital construction is a non-recurring expense, it should not be allocated to any particular year. Since there is no depreciation formula available for governmental accounting it is virtually impossible to compare construction expenditures with any degree of accuracy at this time.

Keeping these difficulties in mind we turn to a comparison of maintenance expenditures by state and county mental hospitals from 1960 to 1964. Table 1

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[5] A "psychopathic hospital" usually implies training and research functions as part of a medical school combined with public service as a quasi-part of the state system of mental hospitals. Langley-Porter in San Francisco and Colorado Psychopathic in Denver are examples.

presents total maintenance expenditures. Colorado expenditures are for the Colorado State Hospital and Colorado Psychopathic Hospital. Table 2 compares Colorado with the other Western states on the basis of maintenance expenditures per patients under treatment. In 1960 only Alaska and Washington exceeded Colorado's $1,388 expenditure. In 1961 when figures became available, Hawaii also exceeded Colorado. Colorado advanced to second behind Alaska in 1962 and remained second through 1964. Expenditures per patient under treatment increased 57% from $1,388 to $2,181 in 1964, an increase ranking second only to Alaska's 114%.

Table 3 presents maintenance expenditures adjusted for the total population of the separate states. Although the Western states spent far less per capita than the national average in both 1960 and 1964, Colorado spent more in both years than the national average -- $6.34 to $5.07 in 1960 and $8.38 to $7.04 in 1964. Colorado maintenance expenditures were higher than any other western state in 1960 and second only to Alaska in 1964. The rate of increase in per capita maintenance expenditure -- 32% in Colorado between 1960 and 1964 -- was surpassed only by Alaska and Arizona in the west but was below the national average of 39%. Table 3 also compares maintenance expenditures per $1,000 of personal income. Here we see that Colorado has exactly the same relationship as in per capita expenditure. Expenditures per $1,000 of personal income increased 16% in Colorado, from $2.78 to $3.23 between 1960 and 1964. Again, only Alaska led Colorado in 1964.

Direct Public Mental Health Costs:

Direct mental health expenditures of state government in Colorado for fiscal 1961-1965 are presented in Tables 4 and 5.[6] Total expenditures reached $23.5 million in 1965. Data for the three major facilities are presented first. Expenditures at Colorado Psychopathic Hospital increased 40% to $2 million in 1965. Fort Logan Mental Health Center reached $3.7 million in 1965 after beginning operations in 1961. Colorado State Hospital increased 36% to over $16 million in 1965. Thus, Colorado State Hospital accounted for 74% of the $21.8 million in expenditures at our state operated facilities for mental health in 1965.(compared to 85% in 1961).

Expenditures for the various other categories were $1.6 million in 1965. The budget for community mental health clinics increased 178% to $568,000 while the mental health program of vocational rehabilitation increased over 300% to $480,000. The budget for alcoholism was $41,000 -- up 41% from 1961.

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[6] An additional expenditure between 1959 and 1965 was for capital construction ($11.1 million at Colorado State Hospital and $8.7 million for Fort Logan Mental Health Center). This is not included in Table 4 since these are not regularly recurring expenditures (as noted above). Note, however, that this $19.8 million for capital construction spread over 6 years, is nearly equal to expenditures for maintenance and salaries in a typical single year. Thus, capital construction has been about 1/6th as expensive as maintenance and salaries in recent years.

Mental health planning and the Division of Psychiatric Services totaled $81,000 in 1965. The Child Welfare expenditure of $528,000 is for private residential care and is based on a sample for December, 1964.

The three state institutions, Colorado State Hospital, Fort Logan Mental Health Center and Colorado Psychopathic Hospital, accounted for 94% of the total budget in fiscal 1961. Four years later, they still consumed 93% of the total. Two of them, Colorado State Hospital and Fort Logan Mental Health Center, are designed for intermediate or long term care -- so called "second echelon care". Note that, expenditures for second echelon care in 1961 by state government consisted of $12.4 million. This was 87% of total state expenditures for mental health that year.

In fiscal 1965, second echelon care still accounted for 85% of the state's budget with Colorado State Hospital accounting for 69%, and Fort Logan Mental Health Center for 16. Thus, even with rapidly increasing expenditures on first echelon care such as community mental health clinics and vocational rehabilitation, first echelon care provided by the state is receiving a relatively constant share of the total state mental health budget!

The 62% increase in mental health expenditures between 1961 and 1965 seems to be quite large, until it is compared to the state's general fund. Expenditures from the general fund increased from $92 million in 1961 to $177 million or 92%.[7] The slower relative increase in mental health expenditures resulted in their decline from 15.4% to 13.0% of the general fund.

Table 5 presents a regional breakdown of expenditures in fiscal 1964, according to the following assumptions:

(1) Colorado Psychopathic Hospital is attributed entirely to Region 11 since most of its patients are from Region 11 although theoretically Colorado Psychopathic Hospital is accessible to the entire state.

(2) Fort Logan Mental Health Center is distributed among the regions served according to the population of those regions.

(3) Colorado State Hospital and vocational rehabilitation expenditures are distributed by population although actual usage of funds would be somewhat different.

(4) Community mental health services include the actual dollar amount of services purchased by the state within each region.

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[7] State of Colorado: Budget Report, annual summaries for fiscal 1961 through 1965.

This distribution allocates over 70% of state mental health expenditures to Region 11. In per capita terms Region 11 receives $12.20 in state expenditures while Regions 1-10 receive only $8.06. Regions 1-10 per capita expenditures ranged from $7.94 in Region 6 to $8.23 in Region 5. Boulder had per capita expenditures of $9.92 while the rest of Region 11 was over $12.00 due to their use of Fort Logan Mental Health Center.

The sources of funds for community mental health in fiscal 1964 are presented in Tables 6, 7, and 8. Total funds were $864,601. Of this, the state contributed 46%, the federal government 7%, and local resources 47%. Of local funds -- $405,637 -- about two-thirds were provided by local governments. 52% of the local share was provided by municipal and county governments, 4% by local health departments, and 12% by school districts. Of the remainder, 17% was derived from fees and 15% from donations and the United Fund.

The percent of community mental health funds obtained from state, federal and local sources are exhibited by mental health regions in Table 7. The state share of clinic funds was limited to $.25 per capita for the area served.[8] This had to be matched on a 50/50 basis by local funds from other sources (except in newly created clinics where the matching ratio could be 3 state to 1 local for the first three years). Due to other state aid, especially support for local aftercare, the state share for all services could sometimes exceed total local matching for clinics alone. In only six regions did the local support exceed 50% of the total funds -- Region 3 (51%), Region 4 (54%), Region 7 (61%), Region 9 (52%), Arapahoe (53%), and Boulder (65%).

Table 8 reviews the source of funds in the mental health regions on a per capita basis. Funds ranged from $.03 per capita in Region 1 to $.84 per capita in Boulder. There were four regions with over $.50 per capita besides Boulder -- Region 2 (.53), Region 3 (.63), Region 7 (.73) and Arapahoe (.55). The lowest four were Region 1 (.13), Region 6 (.30), Region 8 (.30), and Region 9 (.26). These figures point to a great disparity in community mental health services in the state. They heavily reinforce great need for the construction of comprehensive community health centers and funds for operating them on a realistic scale of services.

Indirect Costs:

Estimates of the indirect cost to the economy of the state of Colorado stemming from mental patients admitted to Colorado State Hospital, Fort Logan Mental Health Center, and VA hospitals during fiscal 1963 are developed in

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[8] The entire population of many regions -- notably Regions 1, 5, 8 and 9 -- were not served by community mental health clinics in 1964. Note too that "state aid" includes state funds and some federal funds allotted to Colorado for community mental health programs.

terms of the loss in work years and dollar earnings. Patient data -- especially on average length of stay at the hospital — is still crude and limits the measurable indirect costs to the three institutions mentioned above. The production loss attributable to Colorado Psychopathic Hospital is not calculated due to its special characteristics as a teaching hospital, its use as basically a first echelon service, and its short average length of stay.

The patient statistics at Colorado State Hospital and Fort Logan Mental Health Center are for patients admitted to each institution for the first time within fiscal 1962-63.[9] The patient statistics at VA psychiatric hospitals are for total admission of Colorado residents during calendar year 1963.

It must be remembered that these estimates are for what the mentally ill would have earned if they had not become mentally ill and spent time in the hospital. Thus, any loss of work years or dollar earnings due to a decrease in earnings, or loss of work time due to illness before and after they leave the hospital, is excluded from this analysis. These losses, while undoubtedly sizable, are not measurable since the necessary data is not available. To fill this gap, detailed cohort studies would have to obtain the following information: occupations held before entering the hospital, prior history of mental illness, age at entering the hospital, diagnosis, length of stay, and occupation and earnings after leaving the hospital. A study of this magnitude has not yet been attempted. A good "case register" in Colorado[10] as well as an adequate data collection system among the various mental health agencies would provide most of the information needed to make an estimate of this type.

There are other biases in the data. The contribution of women to society is greatly underrated since the economic loss of a mentally ill woman is calculated only according to employment percentages and wages earned. The economic value of a housewife to society is ignored. Another possible source of underestimate is the use of median incomes which are below average incomes, although the median figure is probably a better indication of the marginal contribution of the individual.

The failure to include percent of unemployment as a correction factor in the data lends a slight upward bias to the estimates. Unemployment data

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[9] Alcoholic admissions to Fort Logan are reported here since their length of stay is much shorter than that estimated for psychiatric admissions to the hospital. The higher length of stay figure was used to make the length of stay data comparable to that of C.S.H. where alcoholics are included in the average length of stay statistics.

[10] See reports of Task Force on Case Registers, and Task Force on Research, in this volume.

was not used since it is not available by age for the state, or by county since 1960 -- and the Colorado economy is changing too rapidly for the 1960 unemployment figure to be reliable. On balance these estimates are low rather than high, but it is impossible to estimate the magnitude by which they understate actual losses to society.

Indirect Cost by Age Groups:

The indirect cost of admissions to a hospital are a function of: (1) the number of admissions; (2) length of stay; (3) types of illness treated.

Work years and earnings lost by admission to the VA, Colorado State Hospital, and Fort Logan Mental Health Center by age and sex are estimated in Tables 9, 10, and 11 respectively. The method of estimation used was:

1. Admissions to each hospital were separated by sex into age groups.
2. Each age group was then multiplied by the percent of the total population in that age group which was included in the labor force.
3. The results of step two were multiplied by the average length of stay for each hospital. This predicts the work years lost in each age group.
4. Work years lost are then multiplied by the median earnings of each age group to find earnings lost.
5. Earnings lost by each age group were then added to obtain the total earnings lost by sex for each hospital.

The total loss in 1963 estimated by age groups, excluding alcoholic admissions to Fort Logan Mental Health Center, was:

Veterans Administration Hospitals	$2,389,967
Colorado State Hospital	11,919,987
Fort Logan Mental Health Center	244,027
Grand Total	$ 13,753,981

If the $556,628 loss attributed to alcoholics at Fort Logan is included the total indirect cost is $14,310,609.

Indirect Cost by Diagnosis:

The method used in estimating indirect costs by diagnosis in Tables 12, 13, 14 and 15 differs from the techniques used for age groups in two ways.

First, the data is grouped by diagnosis rather than age. Second, the median economic data used in the calculations are for the State of Colorado rather than for the United States.

At the two VA hospitals, the largest category of psychiatric admission are functional psychoses. Since these disorders also had the longest average length of stay, production loss in this category was $1.2 million or 70% of the total loss of $1.7 million at the hospital. Organic disorders and neuroses account for another $.4 of a million or 20% of the total loss. Although having 91 fewer admissions, organic disorders accounted for more than twice the loss due to neuroses because of their much longer length of stay.

Unfortunately different lengths of stay by diagnosis are not yet available at Fort Logan and Colorado State Hospital. A detailed cohort study would be necessary for analysis of the different diagnosis similar to that possible for diagnosis at the VA hospitals.

Nevertheless, we shall proceed with the data available using the average length of stay for all disorders. The production loss due to alcoholism for males at Colorado State Hospital and Fort Logan are 53 and 75 percent of the total loss respectively. With a more realistic length of stay figure, these estimates would be much more accurate since many feel that alcoholics leave sooner than other first admissions. Of course, it can be argued that many alcoholics return to one or another mental health facility repeatedly. Hence, the actual time spent in a hospital per year for each alcoholic may be longer than figures for average length of stay of first admission would suggest.

The problem of comparability between hospitals and between diagnostic categories within a hospital are simply highlighted by this data on male alcholic admissions. Any further analysis by diagnostic categories should be made with caution until better data is available.

The total estimated loss by diagnosis found in Table 15 is $13,952,830. Thus, loss by diagnosis is only $400,000 below the estimate derived by age groups. This result would be expected with the similarity of techniques used. If length of stay data by diagnosis had been used at Fort Logan and Colorado State Hospital, the difference in estimates would probably have been even less.

Indirect Cost by Region:

The method of estimation by region used in Tables 16, 17 and 18 are basically the same as those outlined above. Admissions are grouped by ages and regions. They are then multiplied by average length of stay and percent in the labor force to obtain work years lost. Finally, earnings lost are the

produce of work years lost and median earnings. The calculations are carried out in Table 16 for the VA, Table 17 for Colorado State Hospital and Table 18 for Fort Logan. The results are then summed in Table 19.

The total again approximates $14 million for the state. Over 60%, $9 million, of the loss is found in Region 11. As can be seen in Table 20, per capita earnings lost of $8.52 in Region 11 are 36% higher than the $6.22 in the rest of the state. By far the two largest losses are in Denver and Pueblo in both per capita and total amounts. Denver production losses are estimated to be $6.3 million or 12.18 per capita and Pueblo's are $1.8 million or 11.51 per capita. Region 6 at $9.98 is the only other region with a per capita loss of similar magnitude. Three regions have exceptionally low per capita production losses. They are Region 3 ($2.52), Region 4 ($2.75), and Boulder ($2.57).

Table 20 also compares expenditures for public mental health and estimated production loss to the state of Colorado. Only in Regions 6 and 10 are the earnings lost greater than expenditures made for mental health services. Denver is the only sub-region in Region 11 which ranks high in both per capita expenditures and earnings lost. The bias in mental health expenditures for Region 11 is highlighted here.

Table – 1

Maintenance Expenditures of State and County Mental Hospitals, Western States: 1960 – 1964 (In thousands of dollars)

	1960	1961	1962	1963	1964
Alaska	$ 1,081	$ 1,150	$ 1,523	$ 2,114	$ 2,724
Arizona	3,014	3,082	3,600	3,883	5,000
California	73,872	85,135	91,332	100,094	104,334
Colorado (a	11,127	12,338	14,433	16,514	16,138
Hawaii	(b	2,572	2,719	2,841	2,859
Idaho	1,966	2,153	2,166	2,509	2,493
Montana	2,681	2,686	2,987	3,235	3,125
Nevada	968	1,061	1,257	1,391	1,737
New Mexico	1,890	1,841	1,901	2,083	2,432
Oregon	7,636	7,821	10,022	9,617	9,530
Utah	2,144	2,409	2,304	2,506	2,375
Washington	14,207	15,176	14,480	14,541	14,589
Wyoming	1,170	1,283	1,305	1,366	1,467
Mountain States	24,960	26,853	29,953	33,487	34,767
Western States	121,756	138,707	150,029	162,694	168,803
United States	916,483	975,927	1,033,158	1,084,714	1,333,016

a. Figures are for Colorado State Hospital and Colorado Psychopathic Hospital.

b. Not available.

Source; U.S. Department of Health, Education and Welfare, National Institute of Mental Health, Mental Health Statistics, Current Reports, Annual Numbers.

Maintenance Expenditures of State and County Mental Hospitals, Per Patient Under Treatment, Western States: 1960 - 1964.

	1960	1961	1962	1963	1964
Alaska	$2,095	$2,415	$3,173	$4,646	$4,480
Arizona	1,039	1,013	1,104	1,143	1,262
California	1,228	1,346	1,491	1,606	1,660
Colorado	1,388	1,441	1,684	2,050	2,181
Hawaii	(a	1,459	1,486	1,841	1,973
Idaho	1,188	1,199	1,251	1,423	1,374
Montana	941	969	1,027	1,063	991
Nevada	1,059	1,171	1,344	1,422	1,556
New Mexico	1,196	1,081	1,039	1,045	1,174
Oregon	883	919	1,220	1,223	1,307
Utah	1,220	1,406	1,353	1,465	1,268
Washington	1,497	1,591	1,588	1,685	1,748
Wyoming	1,157	1,245	1,175	1,145	1,081
Mountain States	1,149	1,191	1,247	1,344	1,360
Western States(b	1,163	1,237	1,314	1,426	1,465
United States	1,180	1,234	1,298	1,354	1,403

a. Patients under treatment = Resident patients at the beginning of the year and all admissions excluding transfers.

b. Excludes Hawaii

Source: U. S. Department of Health, Education and Welfare, National Institute of Mental Health, Mental Health Statistics, Current Reports, Annual Numbers.

Table - 3

Maintenance Expenditures of State and County Mental Hospitals, Western States: 1960 - 1964.

	Expenditures Per Capita			Expenditures Per $1,000 of Personal Income		
	1960	1964	% Change	1960	1964	% Change
Alaska	$4.78	$12.50	161.5%	$1.73	$4.00	131.2%
Arizona	2.31	3.20	38.5	1.11	2.12	91.0
California	4.70	5.88	25.1	1.72	1.90	10.5
Colorado	6.34	8.38	32.2	2.78	3.23	16.2
Hawaii	-	4.46	-	-	1.73	-
Idaho	2.95	3.63	23.1	1.67	1.80	7.8
Montana	3.97	4.50	13.4	1.98	2.06	4.0
Nevada	3.40	4.34	27.6	1.22	1.34	9.8
New Mexico	1.99	2.46	23.6	1.10	1.22	10.9
Oregon	4.32	5.11	18.3	1.94	1.96	1.0
Utah	2.41	2.40	-4.6	1.26	1.10	-27.0
Washington	4.98	4.98	-	2.17	1.89	-12.9
Wyoming	3.55	4.34	22.3	1.55	1.75	12.9
Mountain States	3.64	4.59	26.1	1.72	1.94	12.8
Western States	4.34	5.45	25.6	1.93	2.15	11.4
United States	5.07	7.04	38.9	2.29	2.76	20.5

Source: Table 4 - 1; U. S. Department of Commerce, Bureau of the Census, Population Estimates, Series P-25, No. 289; U.S. Department of Commerce, Survey of Current Business, Annual Numbers.

Table - 4

State Expenditure on Formal Mental Health Agencies (In Thousands)

	1960-61	1961-62	1962-63	1963-64	Estimate 1964-65
Colorado Psychopathic Hospital	$1,444	$1,514	$1,652	$1,840	$2,022
Colorado State Hospital	11,789	12,915	15,324	15,185	16,051
Fort Logan Mental Health Center	600	1,023	1,822	2,634	3,681
Sub total	13,853	15,452	18,798	19,659	21,754
Community Mental Health (a	204	349	360	500	568
Alcoholism	29	31	33	34	41
Mental Health Program of Vocational Rehabilitation	114	184	264	345	480
Sub total	347	564	657	879	1,089
Mental Health Planning				46	50
Division of Psychiatric Services			41	29	31
Child Welfare (b					528
Sub total			41	75	609
Grand Total	14,180	16,016	19,496	20,613	23,452

a. Includes federal funds and administrative costs.

b. Based on December 1964 and is the only year for which estimate was obtained. These are expenditures by Child Welfare for purchase of service for emotionally disturbed youngsters. Figures prior to 1964-65 are estimates.

Source: State of Colorado, State Budget Report, Annual Numbers.

Table 5

Distribution of State Expenditures by Mental Health Regions, 1963-64
(In thousands of Dollars)

	CPH (a	FLMHC (b	CSH (c	Mental Health Program of Vocational Rehab. (d	Community Mental Health Services (e	State Expenditure
Region 1			$1,002	$23	$ 9	$1,044
2			334	8	10	352
3			516	11	15	542
4			607	14	16	637
5			380	9	8	397
6			304	7	9	320
7			501	12	16	529
8			1,473	33	28	1,534
9			456	10	7	473
10			1,184	27	25	1,236
Denver	$887	$1,383	4,009	92	134	6,505
Adams	256	398	1,169	27	27	1,877
Arapahoe	247	385	1,124	26	35	1,817
Jefferson	300	469	1,397	31	40	2,237
Boulder	151		699	16	22	888
Region 11						13,324
Regions 1-10						7,064
Total	1,840	2,634	15,185	345	399	20,403

a. Distributed to Region 11 according to population of July 1, 1964.

b. Distributed to Denver, Adams, Arapahoe and Jefferson counties according to population as of July 1, 1964.

c. Distributed according to population as of July 1, 1964.

d. State share only.

Table 6

Public Community Mental Health Services[a]: Source of Funds, By Mental Health Regions, Fiscal 1964.

	Total[b]	State	Federal	Local
Region 1[c]	$17,250	$8,767	$4,433	$4,051
2	22,652	10,275	3,563	8,815
3	41,569	14,750	5,500	21,319
4	33,448	15,500	-	17,948
5	18,190	7,594	3,000	7,596
6	12,250	8,687	2,250	1,313
7	48.452	16,050	3,000	29,402
8	56,753	27,717	3,258	25,778
9[d]	15,515	6,919	500	8,097
10	52,763	24,900	4,000	23,863
Denver[e]	249,296	134,219	7,500	107,577
Adams	55,259	27,092	6,991	21,176
Arapahoe	84,907	34,725	5,300	44,882
Jefferson	81,221	39,900	6,225	35,096
Boulder	75,076	21,500	4,850	48,726
Region 11	545,759	257,436	30,866	257,463
Regions 1-10	318,842	141,158	29,504	148,178
Total	864,601	398,594	60,370	405,637

a. Includes Community Mental Health Clinic services and aftercare support (the latter largely federal funds).

b. Individual items may not sum due to rounding.

c. Moffat and Mesa Clinics

d. Bent and Otero Clinics

e. Denver General Hospital, Denver Mental Health Center, Children's Hospital.

Source: State of Colorado, Department of Institutions.

Table 7

Percentage Distribution of Public Community Mental Health Services[a]: Source of Funds, by Mental Health Regions, Fiscal 1964.

	Total Cost[b]	State Percentage	Federal Percentage	Local Percentage
Region 1[c]	$17,250	50.8%	25.7%	23.5%
2	22,652	45.4	15.7	38.9
3	41,569	35.5	13.2	51.3
4	33,448	46.3	-	53.7
5	18,190	41.7	16.5	41.8
6	12,250	70.9	18.4	10.7
7	48,452	33.1	6.2	60.7
8	56,753	48.8	5.7	45.4
9[d]	15,515	44.6	3.2	52.2
10	52,763	47.2	7.6	45.2
Denver[e]	249,296	53.8	3.0	43.2
Adams	55,259	49.0	12.7	38.3
Arapahoe	84,907	40.9	6.2	52.9
Jefferson	81,221	49.1	7.7	43.2
Boulder	75,076	28.6	6.5	64.9
Region 11	545,759	47.2	5.7	47.2
Regions 1-10	318,842	44.3	9.0	46.7
TOTAL	864,601	46.1	7.0	46.9

Footnotes and Source: See Table 6.

Table 8 -

Public Community Mental Health Services:[a] Per Capita Source of Funds, 1964.

	Total[b]	State	Federal	Local
Region 1[c]	$ .13	$ .07	$ .03	$ .03
2	.53	.24	.08	.21
3	.63	.22	.08	.32
4	.43	.20	-	.23
5	.38	.16	.06	.16
6	.30	.22	.06	.03
7	.73	.24	.05	.44
8	.30	.14	.02	.14
9[d]	.26	.12	.01	.14
10	.34	.16	.03	.15
Denver[e]	.47	.26	.01	.20
Adams	.37	.18	.05	.14
Arapahoe	.55	.22	.03	.29
Jefferson	.46	.22	.04	.20
Boulder	.84	.24	.05	.54
Region 11	.50	.24	.03	.24
Region 1-10	.36	.16	.03	.17
TOTAL	.44	.20	.03	.21

Footnotes and Source: See Table 6.

Table 9

Colorado Earnings Lost in V.A. Hospitals, Male, by Age, 1963

Age	(1) Admissions	(2) % In Labor Force	(3) Average Length of Stay	(4) (1)(2)(3) Work Years Lost	(5) Earnings(a	(6) Earnings Lost (4) x (5)
20 - 24	19	86.7%	.6	9.8	$2,468	$24,186
25 - 34	153	95.3	"	87.5	4,906	429,275
35 - 44	385	96.4	"	222.7	5,461	1,216,165
45 - 54	208	94.2	"	117.6	5,112	601,171
55 - 64	52	82.7	"	25.8	4,619	119,170
65+	102	29.5	"	18.1		
TOTAL	817	87.0	.6	426.5	4,736	2,389,967

a. Earnings are United States mediars.

Table 10

Earnings Lost in Colorado State Hospital, Male, by Age: 1962-63

Age	(1) Admissions CSH	(2) % In Labor Force	(3) Work Years Lost[a]	(4) Earnings[b]	(5) Earnings Lost (3)x (4)
14 - 17	92	46.7%	64.4	$586	$37,738
18 - 24	217	86.7	282.2	2,468	696,470
25 - 34	348	95.3	497.5	4,906	2,440,735
35 - 44	473	96.4	684.0	5,461	3,735,324
45 - 54	365	94.2	515.7	5,112	2,636,258
55 - 64	195	82.7	241.9	4,619	1,117,336
65+	167				
Total (14 -65)	1,690	84.2%	2,139.5	4,736[c]	10,663,461

a. 1.5 years is the average length of stay of patients released in 1962-63 from Colorado State Hospital excluding those in the hospital longer than 10 years.

b. United States

c. Colorado

Table 10a

Earnings Lost in Colorado State Hospital, Females, By Age: 1962-63

Age	(1) Admissions CSH	(2) % In Labor Force	(3) Work Years Lost[a]	(4) Earnings[b]	(5) Earnings Lost (3) x (4)
14 - 17	42	27.5%	17.3	$570	$9,861
18 - 24	107	42.4	68.1	1,793	122,103
25 - 34	201	33.9	102.2	2,446	249,981
35 - 44	243	42.6	155.3	2,466	382,970
45 - 54	192	47.3	136.2	2,576	350,851
55 - 64	105	36.5	57.5	2,448	140,760
65+	114				
Total (14 - 65)	890	38.4	512.6	2,585[c]	1,256,526

a. 1.5 years is the average length of stay of patients released in 1962-63 from Colorado State Hospital excluding those in the hospital longer than 10 years.

b. United States

c. Colorado

Table 11

Earnings Lost in Fort Logan Mental Health Center, Male, By Age: 1962-63

Psychiatric Admissions:

Age	(1) Admissions	(2) % In Labor Force	(3) Work Years Lost (1) x (2) x 1/4 [a]	(4) Earnings [b]	(5) Earnings Lost (3) x (4)
19 - 24	53	86.7%	11.5	$2,468	$28,382
25 - 34	48	95.3	11.7	4,906	57,400
35 - 44	28	96.4	6.7	5,461	36,589
45 - 54	26	94.2	6.1	5,112	31,183
55 - 64	11	82.7	2.3	4,619	10,624
65+	2				
TOTAL 14-65	169	87.0	36.8	4,736 [c]	164,178
Alcoholic Admissions:					
Total	514	87.0	111.8	4,736	529,485

a. Average length of stay of psychiatric patients released 1960-1963 was 90 days or 1/4 year.

b. United States median earnings.

c. Median earnings in Colorado

Table 11a

Earnings Lost in Fort Logan Mental Health Center, Female, By Age: 1962-63

Psychiatric Admissions:

Age	(1) Admissions	(2) % In Labor Force	(3) Work Years Lost (1) x (2) x $\frac{1}{4}$ [a]	(4) Earnings [b]	(5) Earnings Lost (3) x (4)
19 - 24	62	42.4%	6.6	$1,793	$11,834
25 - 34	92	33.9	7.8	2,446	19,079
35 - 44	88	42.6	9.4	2,466	22,992
45 - 54	62	47.3	7.3	2,576	18,805
55 - 64	34	36.5	3.1	2,448	7,589
65+	10	-		-	
TOTAL	338	40.6	34.3	2,585 [c]	79,849

Alcoholic Admissions:

TOTAL:	103	40.6	10.5	2,585	27,143

a. Average length of stay of psychiatric patients released 1960-1963 was 90 days or 1/4 year.

b. United States median earnings.

c. Median earnings in Colorado.

Table 12. Colorado Earnings Lost in V. A. Hospitals, Male, by Diagnosis, 1963

	(1) Admissions	(2) % in Labor Force	(3) Average Length of Stay in Yrs.(a	(4) (1)(2)(3) Work Years Lost	(5) Earnings(b	(6) (4) x (5) Earnings Lost
1. Functional Psychoses	319	87.0%	.89	247.0	$4,736	$1,169,792
2. Organic Disorders	123	"	.53	56.7	"	268,531
3. Neurosis	214	"	.14	26.1	"	123,610
4. Personality Disorders	83	"	.10	7.2	"	34,099
5. Alcoholism	76	"	.11	6.3	"	29,837
6. Retarded	2	"	.33	.6	"	2,842
TOTAL	817	87.0	.50	335.4	4,736	1,683,174

a. Length of stay derived from sample consisting of Denver residents and are fractions of one year.

b. Earnings are the Colorado median.

Table 13 Colorado Earnings Lost in Colorado State Hospital by Sex, by Diagnosis: 1962 - 1963

Diagnosis	Male (1) Admissions	Male (2)[a] Work Years Lost	Male (3)[b] Earnings Lost	Female (4) Admissions	Female (5)[a] Work Years Lost	Female (6)[b] Earnings Lost
1. Functional Psychoses	285	360.8	$1,708,749	372	214.3	$553,966
2. Organic Disorders	88	111.4	527,590	54	31.1	80,394
3. Neurosis	100	126.6	599,578	139	80.1	207,058
4. Personality Disorders	127	160.8	761,549	69	39.7	102,624
5. Alcoholism	902	1,141.9	5,408,038	191	110.0	284,350
6. Retarded	48	60.8	287,949	21	12.1	31,278
7. Situational Disorders	31	39.2	185,651	21	12.1	31,278
8. Other	109	138.0	653,568	23	13.2	34,122
TOTAL	1,690	2,139.5	10,132,672	890	512.6	1,325,071

a. Work years lost = admissions x length of stay (1.5 years) x percent in labor force (Male - 84.4; Female = 38.4) .

b. Earnings lost = work years lost x earnings (Male = $4,736; Female = $2,585

Table 14 Colorado Earnings Lost at Fort Logan Mental Health Center by Sex, by Diagnosis: 1962-1963

Diagnosis	Male (1) Admissions	Male (2) Work Years Lost[a]	Male (3) Earnings Lost	Female (4) Admissions	Female (5) Work Years Lost[a]	Female (6) Earnings Lost[b]
1. Functional psychoses	93	20.2	$95,667	201	20.4	$52,734
2. Organic Disorders	3	.5	2,368	6	.6	1,551
3. Neurosis	32	7.0	33,152	86	8.7	22,490
4. Personality Disorders	29	6.3	29,837	37	3.8	9,823
5. Alcoholism	511	111.1	526,170	102	10.4	26,884
6. Retarded	2	.4	1,894	1	..1	259
7. Situational Disorders	2	.4	1,894	3	.3	776
8. Other	5	1.1	5,210	4	.4	1,034
Total	677	147.2	697,139	440	44.4	114,774

a. Work years lost equals admission x Length of stay ($\frac{1}{4}$ year) x Per cent in Labor Force (Male = 87.0; Female = 40.6

b. Earnings lost = work years lost x earnings (Male = $4,736; Female = $2,585)

c. Alcoholics assumed to remain in hospital 3 months although the length of stay is two weeks.

Table 15 Total Earnings Lost at Colorado State Hospital, Fort Logan Mental Health Center and Veterans Administration Hospitals, for Colorado, by Diagnosis, by Sex, 1963.

Diagnosis	Male	Female	Total
1. Funcational Psychoses	$2,974,208	$606,700	$3,580,908
2. Organic Disorders	798,489	81,945	880,434
3. Neurosis	756,340	229,548	985,888
4. Personality Disorders	825,485	112,447	937,932
5. Alcoholism	5,964,045	311,234	6,275,279
6. Retarded	292,685	315,537	608,222
7. Situational Disorders	187,545	32,054	219,599
8. Other	658,778	35,156	693,934
TOTAL	12,512,985	1,439,845	13,952,830

a. Individual items may not sum due to rounding.

Table 16

Earnings Lost at V.A. Hospitals, by Regions: 1962 - 63

	Admissions	Work Years Lost[a]	Total: Earnings Lost[b]
Region 1	87	45.4	$ 215,014
2	18	9.4	44,518
3	14	7.3	34,573
4	18	9.4	44,518
5	14	7.3	34,573
6	19	9.9	46,886
7	11	5.7	26,995
8	46	24.0	113,664
9	27	14.1	66,778
10	56	29.2	138,291
Denver	358	186.9	885,158
Adams	38	19.8	93,773
Arapahoe	45	23.5	111,296
Jefferson	42	21.9	103,718
Boulder	24	12.5	59,200
Region 11	507	264.6	1,253,146
Region 1-10	310	161.7	765,811
TOTAL	817	426.3	2,018,957

a. Work years lost = Admissions x length of stay (.6 years) x percent in labor force (87.0)

b. Earnings lost = work years x earnings (4,736)

Table 17 Earnings Lost at Colorado State Hospital, by Regions, By Sex: 1962-1963

	Male			Female			
	(1) Admissions	(2) Work Years Lost[a]	(3) Earnings Lost	(1) Admissions	(2) Work Years Lost	(3) Earnings Lost	Grand Totals
Region 1	86	108.9	$515,750	38	21.9	$56,612	$572,362
2	21	26.6	125,978	13	7.5	19,388	145,366
3	19	24.1	114,138	8	4.6	11,891	126,029
4	26	32.9	155,814	9	5.2	13,442	169,256
5	38	48.1	277,802	19	10.9	28,176	255,978
6	54	68.4	323,942	16	9.2	23,782	347,724
7	40	50.6	239,642	13	7.5	19,388	259,030
8	106	134.2	635,571	65	37.4	96,679	732,250
9	48	60.8	287,949	13	7.5	19,388	307,337
10	242	306.4	1,451,110	107	61.6	159,236	1,610,346
Denver	715	905.2	4,287,027	361	207.9	537,422	4,824,449
Adams	63	79.8	377,933	49	28.2	72,897	450,830
Arapahoe	96	121.5	575,424	88	50.7	131,060	706,484
Jefferson	111	140.5	665,408	80	46.1	119,168	784,576
Boulder	25	31.7	150,131	11	6.4	16,544	166,675
Region 11	1,010	1,278.7	6,055,923	589	339.3	877,090	6,933,033
Region 1-10	680	861.0	4,077,696	301	173.3	447,981	4,525,677
TOTAL	1,690	2,139.7	10,133,619	890	512.6	1,325,071	11,458,710

a. Work years lost = admissions x length of stay (1.5 years) x percent in labor force (male - 84.4, Female = 38.4)

b. Earnings lost = work years lost x earnings (male = 4,736; Female = 2,585)

Table 18 Earnings Lost in Fort Logan Mental Health Center, By Region, By Sex: 1962 - 63

	Male			Female			Grand Totals
	Admissions[a]	Work Years Lost[b]	Earnings Lost[c]	Admissions[a]	Work Years Lost[b]	Earnings Lost[c]	
Denver	479	104.3	$493,965	266	27.0	$69,795	$563,760
Adams	57	12.4	58,726	45	4.6	11,891	70,617
Arapahoe	71	15.4	72,934	67	6.8	17,578	90,512
Jefferson	71	15.4	72,934	62	6.3	16,286	89,220
Total	678	147.5	698.560	440	44.7	115,550	814,100

a. Includes psychiatric and alcoholic admissions.

b. Work years lost = admissions x length of stay ($\frac{1}{4}$ year) x percent in labor force (male = 87.0; Female = 40.6)

c. Earnings lost = work years lost x earnings (male = $4,736; female = $2,585).

Table 19

Earnings Lost at Fort Logan Mental Health Center, Colorado State Hospital, and V. A. Hospitals; by Mental Health Regions: 1963

	FLMHC	C.S.H.	V. A.	Total
Region 1	$ -	$572,362	$215,014	$787,376
2	-	145,366	44,518	189,884
3	-	126,029	34,573	160,602
4	-	169,256	44,518	213,774
5	-	255,978	34,573	290,551
6	-	347,724	46,886	394,610
7	-	259,030	26,995	286,025
8	-	732,250	113,664	845,914
9	-	307,337	66,778	374,115
10	-	1,610,346	138,291	1,748,637
Denver	563,760	4,824,449	885,158	6,273,367
Adams	70,617	450,830	93,773	615,220
Arapahoe	90,512	706,484	111,296	908,292
Jefferson	89,220	784,576	103,718	977,514
Boulder	-	166,675	59,200	225,875
Region 11	814,110	6,933,013	1,253,146	9,000,269
Region 1-10	-	4,525,677	765,811	5,291,488
TOTAL	814,110	11,458,690	2,018,957	14,291,757

Source: Tables 16, 17, and 18.

Table 20

Comparison of Actual Public Mental Health Expenditures and Earnings Lost at Fort Logan Mental Health Center, Colorado State Hospital, and V. A. Hospitals

	Amount in Thousands of Dollars		Per Capita		
	Expenditure	Earnings Lost	Expenditure	Earnings Lost	Earnings Lost as a % of Expenditure
Region 1	$1,052	$787	$8.07	$6.18	76.6%
2	365	190	8.52	4.45	52.2
3	569	161	8.65	2.52	29.2
4	654	214	8.38	2.75	32.8
5	407	291	8.44	6.12	72.5
6	323	395	8.01	9.98	124.6
7	561	286	8.46	4.38	51.8
8	1,563	846	8.19	4.79	58.5
9	482	374	8.21	6.44	78.4
10	1,264	1,749	8.17	11.51	140.9
Denver	6,620	6,273	12.61	12.18	96.6
Adams	1,905	615	12.62	4.24	33.6
Arapahoe	1,867	908	12.84	6.45	50.2
Jefferson	2,278	978	12.82	5.98	46.6
Boulder	941	223	10.51	2.57	24.5
Region 11	13,611	9,000	12.46	8.52	68.4
Region 1-10	7,240	5,291	8.26	6.22	75.3
TOTAL	20,851	14,292	10.59	7.50	70.8

a. Expenditures are for 1964 and earnings lost are for 1963.

Source: Tables 5, 8, and 19.

TASK FORCE ON ARCHITECTURE: Summary of Recommendations

The Task Force on Architectural Problems presented by the concept of community mental health centers was conceived in the Fall of 1964. As set up, it was composed of John Brokaw and Richard Brown of the firm of Brown, Brokaw & Bowen; Daniel Havekost of the firm of Papachristou and Havekost; Victor Hornbein of the firm of Hornbein & White. Clyde Dorset of the National Institute of Mental Health was a special consultant for the group in June, 1965.

Recommendations:

1. A comprehensive mental health center must provide a wide range of services for which traditional hospital space designed around the concept of "beds" is quite inappropriate. New solutions for new treatment purposes are required if architecture is to serve treatment needs effectively.

2. A community mental health center should be so located as to easily integrate into the fabric of its surrounding community -- it should be a "community center" rather than an isolated place for the mentally ill.

3. A center's design should impart a balanced sense of security and stability without imposing a sense of confinement.

4. A high degree of adaptability should be one of the architectural goals. Treatment methods are rapidly evolving and spaces may be put to a succession of different uses during the lifetime of a center.

5. Semi-private spaces and reasonably large public spaces should both be available if a center is to offer patients a full range of treatment modalities.

6. Ambiguous or muddled design -- or elaborate aesthetic effects -- make unnecessary demands upon the severely disturbed patient's perceptual faculties. Clearly defined spaces with fairly straightforward logic to their design are desirable.

7. Controlled spaces which assist in lending cohesion and a feeling of belonging to a limited group of manageable size -- rather than exposing the patient to a host of outsiders beyond his immediate "team" -- are important. Huge day rooms or wards should be relegated to the past.

8. The fundamentals of good architectural design anywhere are applicable to centers as well. The center should be expressive of its local surroundings, a comfortable and interesting addition to its environment.

9. Three basic "types" of centers appear feasible in Colorado:

   Major urban for the large city, its site subject to restricted size, its services likely to be elaborate and of many varieties;

   Suburban or small urban, with generally more room for the site, simplified parking problems, a capacity for solid basic treatment services;

   Rural, serving a relatively large area sparsely populated, plenty of physical space, services likely to be far more limited and stripped to basics.

10. This task force should continue in being, possibly with enlarged membership, to maintain a dialogue between the mental health professions and their citizen allies and the design professions. Further research, possible prototype designs, stimulation of architectural graduate students, etc., could serve a useful purpose in Colorado.

FINAL REPORT: Task Force on Architecture

Introduction:

The Task Force on the Architectural Problems of Community Mental Health Centers held its initial meeting on January 25, 1965. The Task Force was composed of Victor Hornbein of the firm of Hornbein & White, John Brokaw and Richard Brown of Brown, Brokaw & Bowen, and Daniel Havekost, Chairman, of Papachristou and Havekost, all practicing architects in the city of Denver. Meeting with the task force at this meeting were Dr. Hans Schapire and Stanley Boucher of the State Department of Institutions to outline the problems facing the task force.

It was decided that a number of existing mental health facilities in Colorado would be visited for direct discussions with treatment staff and administrators. The task force would attempt to assess how well the facilities worked and how their architecture could be improved in the light of today's rapidly evolving treatment methods. It was considered especially important to explore likely directions in which treatment would move in the future and how this would effect the architecture which was to house it.

The report was to be a tool for all groups interested in planning for the construction of comprehensive mental health centers. Its purpose was to present initial guidelines which such groups could use as a take-off point for solving the architectural challenges of a center adapted to our own unique communities.

The group felt that to develop an actual prototype or series of models of "ideal" mental health centers would be premature. Nevertheless, as a sort of sideline in hope to stimulating interest among students in this new concept, the task force arranged with the School of Architecture at the University of Colorado to undertake the solution of a comprehensive center as a problem for their Junior Class in Architecture. A number of very interesting solutions were developed.

The Task Force visited the following facilities: Fort Logan Mental Health Center (twice), Colorado Psychopathic Hospital (Adult Clinic, Children's Day Care Center and Inpatient Service), Boulder Mental Health Center, Boulder Memorial Hospital Inpatient Wing for Psychiatric Patients, and St. Joseph's Hospital Psychiatric Service Ward. Each had both good and bad points in terms of architecture serving treatment needs. In certain repsects, all suggested striking areas for hindsight improvement.

At its final meeting prior to compiling this report, the Task Force met with Clyde Dorset, architect on the staff of the Community Mental Health Facilities Branch of NIMH. This was a brainstorming session in which Mr. Dorset reviewed certain exciting developments for centers in the East, and the Task Force shared their impressions on Colorado's special problems. A brief transcript of this animated encounter is included as an appendix.

This report will attempt to summarize, then, the more obvious criteron for designing a comprehensive community mental health center in a Colorado community. It includes, too, some loosely drawn suggestions concerning desirable characteristics of this kind of architectural building type.

The Task Force wishes to thank the institutions noted above for their ready cooperation in the development of this report. Our special thanks go to Mr. Stanley Boucher who guided us from one facility to another as we collected the information for this report.

Basic Criteria:

Current architectural vocabulary does not provide us with any ready-made help for the solution of a comprehensive mental health center plan. Consequently, we must begin the search for an appropriately planned environment for this use by analyzing its basic physical as well as psychological requirements.

(1) In exploring the physical aspects of the problem, we are at once confronted by federal statutory language controlling the conditions which receipients of financial aid must meet. In order to qualify for a federal grant, a community mental health center must include the following five essential elements: 1) out-patient services; 2) in-patient services; 3) partial hospitalization (day care); 4) emergency services (twenty-four hour); and 5) consultation services. Of the first three, each presents an architectural challenge of somewhat differing order. The last two, emergency services and consultation, do not necessarily require specialized facilities in their own right -- except perhaps in a large center in a highly urban area.

In addition to these basic five services, five more -- pre-care and after care, research, diagnostic, rehabilitative and educational functions - should be incorporated in any really complete comprehensive center. Note that most of these functions require a facility radically different from most current hospitals based primarily upon the concept of "beds" and "bedspace".

(2) A community mental health center should be located so that it can be integrated into the fabric of its surrounding community. It is of fundamental importance that such an institution occupy a central position with respect to community activities, transportation routes, and public service facilities. Furthermore, a comprehensive center should have a prominent location in order that it may become a familiar community meeting place as well as a treatment facility. It has been suggested that meeting rooms within the center should be adapted to serve non-clinical functions, thus promoting the synthesis of community and health center activities and removing some of the persisting stigma attached to mental illness and its treatment.

(3) The mental health center should impart a sense of security to its inhabitants without imposing a sense of confinement. Physical security can be achieved through the proper coordination of spaces and enclosures, without sacrificing a desirable sense of freedom. Psychological security can be provided through the incorporation of a familiar, stable environment which makes use of permanent materials, clearly defined structures and straightforward planning.

(4) In order that the treatment centers will enjoy a long and satisfactory term of use, they should be planned with a high degree of adaptability in order that changing requirements can be met with a minimum of disruption. Physical requirements will almost inevitably fluctuate with the continuing development of novel methods of treatment. Consequently, provision must be made for a variety of spaces which can serve numerous functions or be conveniently changed to accommodate new requirements. Building plans should be as "flexible" as possible, yet consistent with the retention of overall character and sense of security.

(5) The planning of any comprehensive center should include semi-private spaces as well as reasonably large public spaces in order that patients will be afforded the opportunity of adjusting to a variety of social conditions and environments. Many psychiatrists now predict that future methods of treatment will rely more and more heavily upon drugs taken by ambulatory patients along with such techniques as group therapy, family therapy, work therapy, etc. In consequence, psychiatrists forecast a de-emphasis on in-patient care while they see an expanding future for the field of partial care, outpatient therapy, "walk-in-clinics" for emergencies, and consultation with a host of allied treatment agencies. The resulting facilities will need to include more and larger offices (160 square feet minimum), a variety of meeting lounges, generous occupational and recreational therapy areas. The need for traditional hospital-type beds will be minimized.

(6) In order to gain perspective on the psychological functions of architectural design in constructing community mental health centers, it is important to understand some basic problems of the acutely mentally ill person. When highly disturbed, such a person finds it difficult to orient himself in society and its environs. He may have major difficulty relating himself to some basic factors of identity such as his own person, place, time, and, most fundamentally, to other human beings. Consequently, in order to create a suitable environment for the severly mentally ill person, it is necessary to avoid design which will make heavy or unusual demands upon the patient's impaired perceptual ability.

Hence, the architect should eliminate ambiguous or muddled design. He should attempt to minimize complication and to simplify the intricacies of the environment even though they may seem aesthetically interesting. A suitable environment should not utilize over-large, uncontrolled spaces nor should it permit situations in which an excessive number of strangers (other teams of patients, visitors, maintenance staff, etc.) impinge upon any given patient. A properly designed mental health facility should provide unambiguous forms, colors, lighting and textures and insure that corridors are clearly defined and logically planned.

(7) Psychiatrists tell us that there is a definite need for limiting social contact to a manageable group, a so-called "social module" (corresponding to one's family or circle of friends in normal life), as an integral part of mental health therapy. When a sick person is exposed to a large

number of possible relationships beyond his immediate patient group or "team," he is frequently baffled and overwhelmed. This can result in a worsening of his mental condition and a strengthening of the tendency toward withdrawal. The enormous dayrooms and large wards of the older state hospital are examples to be avoided.

The architectural plan can most effectively aid in the patient's treatment by providing a variety of social environments which can serve as havens or stimulants according to individual needs. The ensuing design should provide a situation in which social interaction is limited to the point at which stimuli toward panic and withdrawal are at a minimum while the opportunity for realization of a suitable social role is at its best.

(8) Of course, factors which govern good architectural design anywhere should be employed to produce a comfortable, interesting and appropriate environment. The factors of site, sun-exposure wind, overall climate, regional precedents and current building technology should be prime determinants in the design of each particular facility. In order to be effectively integrated into its community, the comprehensive center should be expressive of the dominant local characteristics and appropriate to its surroundings, historical as well as regional. A mental health center should have a character which positively states its purpose — namely a community institution for the treatment of the mentally ill. Incidentally, the task force feels that a community mental health building should not simply mimic a pseudo-residential style, as is currently popular for some community buildings. It will be extremely important to the development and acceptance of any community mental health center that the proper image be translated to the community residents as well as the center patients.

(9) In Colorado, the task force sees three basic types of community mental health centers which can be distinguished as providing distinctively different requirements, and as a result, different building approaches.

The first is the major urban community mental health center for a community consisting of densely populated city areas such as Denver. The major urban community center will usually have a restricted site requiring compact planning and should be located near public transportation routes. Such a center could consist largely of office-interview rooms, emergency treatment facilities, family and group meeting areas, and adequate recreational and occupational therapy spaces. Education programs for many specialities are likely to be ongoing. Special research facilities may be required. This urban center should be sufficiently continuous with its surroundings and traditions as to be an integral part of the community it serves.

Secondly, the surburban or small urban community mental health center, serving a suburban community such as Englewood, Aurora, or a small urban city like Colorado Springs, Fort Collins, Boulder, etc. The typical center of this type will be afforded a reasonably large site, should be located in proximity to main highway arteries and provide adequate parking space.

Such a center could logically emphasize day care facilities, superior out-patient treatment, educational facilities and fine recreational space, as well as the usual comprehensive facilities. The overall character of a suburban center should be in keeping with its surroundings in terms of quality, scale and use of materials.

The third general classification of community mental health center can be thought of as a rural center. A Colorado rural center would serve a group of patients coming from a geographically far-flung but sparsely populated portion of the state. The rural facility can be afforded a generous site indeed, again located in close proximity to main transportation crossroads. It may logically emphasize brief in-patient care, pre-care, after care, out-patient service and consultation. It seems natural that a rural center would encounter less need for educational or research facilities. A rural Colorado center could appropriately have a character in keeping with the region and architectural traditions of its surroundings.

(10) In the course of developing the Architectural Task Force on Comprehensive Community Health Centers, it has become increasingly evident that a number of continued studies should be made in order to establish additional criteria to guide the future development of the proposed centers. First of all, it is felt that substantial benefit can be derived from the maintenance of the Architectural Task Force as a vehicle for continued dialogue between the mental treatment professions and design professions. The resulting information, if kept current, can be of great help in terms of mutual understanding between professions and in the eventual development of master plans for the comprehensive centers.

Secondly, it is felt that considerable research needs to be carried out to determine in greater detail the suitability of placing emphasis on particular treatment programs for centers which are to serve various communities. It is at once evident that treatment needs may vary according to population density, age and character of the patients and their surrounding environments. In order to establish the unique attributes of various community centers, surveys of need, statistical studies and character analyses should be examined in depth.

Thirdly, it is highly recommended that competent architectural firms be commissioned to develop schematic master plans for comprehensive community centers suitable to various areas of Colorado and incorporating the unique attributes as well as basic principles which will apply to the various centers. It has been suggested that a first step might be taken toward tangible planning by encouraging an interested architectural graduate student to develop a typical master plan as a thesis.

APPENDIX A: Final Brainstorming Session,

Task Force on Architecture

Time: Wednesday, June 23, 1965

Place: Fort Logan Mental Health Center

Mr. Stanley Boucher began the meeting with the introduction of a visiting architectural consultant from the National Institute of Mental Health, Mr. Clyde Dorsett. Others in attendance were Miss Irene Kohl (U. S. Public Health Service),Mr. Edward Van Natta (Adams County Mental Hygiene Clinic), Dr. Abe Heller (Psychiatric Service, Denver General Hospital), Dr. Sherman Nelson and Mr. Howard Krasnoff (both of Fort Logan Mental Health Center), and the architects of the Task Force, Mr. Brown, Hornbein, and Havekost.

The purpose of the Task Force was reviewed by Mr. Boucher: the need to focus on criteria which would be helpful to local citizens and state consultants in setting about constructing a community mental health center. Mr. Havekost set forth three guideline discussion issues: (a) the possibility of almost immediate obsolescence of buildings designed now due to the rapid development of modes of treatment; (b) the problem of small comprehensive centers vs. large institutional structures; and (c) the relationship, if any, between architecture and actual treatment.

Mr. Dorsett pointed out the present lack of knowledge regarding what future directions treatment will take. He therefore suggested that design be adaptable to many kinds of treatment. He discussed six different community mental health centers which are underlain by six different concepts of community mental health. Four of these various ideas were applied in the development of mental health centers in the rural environment of Hayes, Kansas, the university environment in a section of Dallas, Texas, the urban environment of Baltimore, Maryland, and the fast-growing urban evnironment of Los Angeles, California respectively.

Mr. Dorsett explained that although all of these centers were begun as small comprehensive mental health centers, only one managed to remain so. All of the projects except the one in Hayes, Kansas soon began to house welfare agencies as well ascommunity mental health facilities. Mr. Dorsett's conclusion was that community mental health centers must be an integral part of the community.

Mr. Dorsett then commented on Mr. Havekost's third guideline for discussion. He affirmed that there was a definite relation between architecture and treatment, and that architecture could have therapeutic effects by itself. Mr. Hornbein questioned how such a relationship could be substantiated and researched other than impressionistically. Mr. Dorsett replied by pointing to the University of Utah's experiments with movable walls and ceilings, which are used to gauge the relative success of group therapy as a variable dependent upon architectural spaces.

Mr. Van Natta pointed out that in addition to its therapeutic value, good architectural leadership could help to break down the widespread resistance to mental health problems and treatment facilities. He stressed that a pleasing and practical structure could help to effect the concrete identification of a given community with its own mental health center. Once this identification was complete, the fear of going to a clinic for mental health would diminish noticeably. Mr. Van Natta also posed the question of how comprehensive any center should be when general hospitals and other such facilities are taken into account?

When asked by Miss Kohn what age-group divisions had worked out best in the six experimental community centers, Mr. Dorsett replied that it depended upon the community involved. In some communities all age groups had been brought together under a family treatment type concept. In others, the adolescent group in particular, had been separated off from other age groups and given a center of its own. He again stressed that the mental health centers should be integral parts of the communities which housed them.

Mr. Hornbein raised the problem of institutional vs. non-institutional settings for treatment by asking what sort of value decentralization could have for treatment. He suggested that teams scattered throughout the city were more convenient and more effective than one monolithic central organization. He emphasized that day-care treatment made life easier for the patient than in-patient care. Dr. Heller added that a great deal of criticism regarding general hospital mental care centered upon the "too hospital", sterile, all-white character of hospital settings. Miss Kohl then raised the question of whether some patients respond better to a hospital setting than another type of environment. Dr. Heller affirmed that in some cases patients do respond better to an undisguised hospital surrounding and therefore some mental health facilities should be kept within the general hospital.

It was generally agreed that community health centers must be integral parts of the community. Mr. Dorsett suggested that regular community meetings and other activities be held in rooms of the mental health center so that the building will take on a community character. Mr. Van Natta stressed that mental health should be identified closely with public service and therefore agencies for both types of services should be housed in the same building. Mr. Dorsett and Mr. Van Natta both felt that there was no set rule as to the superiority of integrated public service and mental health facilities vs. integrated general hospital and mental health facilities or vice versa. They agreed that it was up to the community to decide which set of integrations were best for its members.

Mr. Van Natta brought up discussion about a changing trend in psychiatric care. He pointed out that mental health professionals are much more aggressive now then they have ever been before. They feel it is no longer enough to sit back and let patients come to them, but are becoming more and more convinced of the value of "psychiatric house calls," etc. Mr. Hornbein raised the suggestion whether house calls in the field of mental health imply seeing the

patient against his own will. Dr. Heller replied that such home visits could often prevent the trauma of being carried off to a mental health clinic by sheriff-appointed "hurly-burlies." Mr. Van Natta added that many housewives have socio-psychiatric problems with which they could cope themselves if they could simply talk to others who understand. Many of these housewives find it impossible to get to a mental health clinic, however, because of child-care or house-hold responsibilities, or lack of transportation. House call treatment in such cases could be an extremely effective method for preventing frustrations from becoming serious, unanswerable problems.

Mr. Hornbein brought up the question of what emphasis face-to-face single individual treatment should have compared to family-centered or group therapy. Dr. Heller stressed that regardless of which treatment methods gain predominance, attention should be paid to the chronic problem of insufficient conference room space. He stressed that staff personnel must also have office space and a "place to hang their hats." Dr. Heller and Mr. Dorsett agreed that design must take account of a mixed set of treatment methods.

Mr. Hornbein suggested that with complete flexibility, one loses environmental positives. Mr. Dorsett pointed out that there were different definitions of flexibility. Flexibility could mean movable partitions and ceilings or it could mean simply a variety of spaces. He added that the community in question should determine the type and extent of flexibility to be incorporated in a given mental health center. Mr. Hornbein agreed that the community must finally determine its health center but that guidelines should be provided by the architect. He stressed the adaptability of human beings as far superior to that of buildings. Dr. Heller agreed but pointed out that sick persons are less adaptable than healthy ones. Mr. Van Natta added that even healthy persons find it difficult to adapt in some situations. He gave the example of his own staff, located as it was in an underground level environment. He stated that many of his staff members became almost visibly depressed after awhile in their basement quarters.

The question of large day-care rooms vs. more intimate conference rooms was raised by Miss Kohl. She explained that many normal families, when confronted with such a large and overwhelming space, might be stymied. Mr. Van Natta added that he preferred to have patients participate in family therapy in the smaller confines of his office rather than to have them taken to a large day-care room. Mr. Dorsett explained that of the four different types of day-care rooms applied in the experimental Copenhagen mental health center, a small bar-like room with few lights, a fireplace, and small setees was most popular. He stressed that many different types of spaces should be made available to the patients.

Mr. Hornbein suggested that for in-patient treatment, the architect should design a self-continined community, a village. Mr. Dorsett objected that such a concept might cut the patient off from the community by isolating him in his own mental health colony. Dr. Heller pointed out that the distinction between

in-patients and day-care patients should not be forgotten. The day-care patients should be exposed to and integrated with the community as much as possible. The in-patients, on the other hand, are in-patients by virtue of the fact that they cannot adequately cope with the community and they must therefore be insulated from it. An artificial community must be created to some degree for in-patients, a community which will accept them rather than reject them.

Mr. Havekost then raised the question of what character a mental health building should have. Mr. Dorsett felt that a mental health center should tend toward the domestic in its adaptability and oneness but that it should not be a home. He also stressed that the transition from the home to the health center shouldn't be a violent or radical one. He suggested that cold, marble entrance-ways should be rejected in favor of carpeted hallways with paintings and hangings. Mr. Havekost objected that it is necessary to know what a building is and what it stands for. It must be concretely identifiable in Mr. Van Natta's words. Dr. Heller added that a health center is a different kind of community. It may have functions which are identical with those taking place in the community which surrounds it but the fact is inescapable that a mental health community is an "artificial" construction. Mr. Van Natta further added that this difference in character between the community and the mental health community within it was positively important and should not be slurred over in design. He pointed out the danger that an institution for mental care could become too "homey" and too comfortable for the patients, thereby discouraging them from getting well and leaving.

Mr. Hornbein explained that the awful architectural qualities associated with old-line institutions need not be duplicated in a modern institutional building. He affirmed that a building must say what it is, and therefore that an institution should not try to copy a residence, but that also it need not have the monstrous "institutional" characteristics usually associated with institutions. Mr. Dorsett stressed that the health center must reflect the community and not the architect. Mr. Boucher, Mr. Hornbein and Mr. Van Natta agreed that although the community character must be expressed, the architect should guide the community in its mental health center project.

TASK FORCE ON RESEARCH: The Role Of The Behavioral Sciences In A Modern Mental Health Program

The Task Force on Research was organized in April and May of 1964. Harl Young, Ph.D., then a Research Psychologist at the Veterans Administration Hospital in Denver (and now in private practice), agreed to serve as Chairman. Eighteen persons joined him, scientists and a few administrators. The group agreed to take a look at the entire field of mental health research in Colorado and make whatever recommendations it thought would be appropriate for this state.

Using the Report of the Joint Commission on Mental Illness and Health as a starting point, the group split into three sub-committees and developed the following basic recommendations:

Summary of Basic Recommendations:

1. There is every reason to believe that a mental health program involving an expenditure of millions of dollars every year for services would benefit from the allocation of a small fraction of such funds for evaluating the quality and effect of such services, and developing new knowledge which would eventually result in better services. Accordingly, the Task Force on Research believes that Colorado should ultimately devote approximately 2½ percent of the funds it spends for the care of the mentally ill for research. The Task Force recognizes that such an expenditure should be graduated over a period of time, but that it should reach the 2½ percent figure as rapidly as is commensurate with recruiting adequate staff and formulating research goals. Such a recommendation is in accord with the Report of the Joint Commission on Mental Illness and Health.

2. A Mental Health Research Advisory Council (including, if possible, Mental Retardation) should be established which would receive and distribute research funds, from the state and other resources. The Council would be appointed by the Governor and should include:

   One representative from each of the 5 principal state agencies involved in serving human needs (Institutions, Public Welfare, Public Health, Education, and Rehabilitation).

   One representative from each of the major universities (Colorado University, Colorado State University, Colorado State College, University of Colorado Medical School, and Denver University).

One representative from each of the major professional organizations (District Branch of the American Psychiatric Association, Colorado Psychological Association, National Association of Social Work, Colorado Medical Society, and Colorado Nurses Association).

Six representatives from the general public.

3. This 21 member council should develop its own bylaws, elect a chairman from its membership, and divide into appropriate working sub-committees.

4. This Research Advisory Council should primarily fund research personnel within Colorado -- but should be allowed to fund personnel from out of state also where this is to the interest of better meeting Colorado's needs.

5. As a beginning, the Task Force suggests that ½ percent of the total mental health budget of the State of Colorado be funded to the Council for use in the operation of research services.

6. The bulk of such funds should be devoted to initiating program evaluation.

7. Within the Department of Institutions there should be established a Planning and Research Section with an initial budget of $50,000. The research director should have a background in the behavioral sciences. This section should work closely with the Research Advisory Council.

8. The Task Force favors the general principal of setting up pilot studies designed to explore the feasibility of a <u>case register</u>. The Task Force believes that it is <u>mandatory</u> that adequate safeguards be provided for confidentiality in as much as this is the single most difficult hurdle which must be faced if a case register is to be useful from a research point of view but not simultaneously a danger to the individual rights and liberties of patients and clients.

9. The Research Task Force believes that Colorado statutes should be revised so that research project requests originating within state agencies should not be required to be approved by the Division of Accounts and Control since such a procedure requires that a project application be reviewed by persons having no specific competency in behavioral science research.

10. Every effort should be made to seek new administrative devices and more imaginative arrangements between existing administrative channels in order to attract gifted researchers and to serve as a stimulus for inaugurating a first class mental health research program in Colorado.

REPORT OF THE TASK FORCE ON MENTAL HEALTH RESEARCH

Submitted by Dr. Harl H. Young,Ph.D,
August 19, 1965

I. Introduction

A great many Americans have become familiar with such statistics as the estimate that one out of every ten of us will have emotional problems so severe sometime in our lives as to require professional help. Most of us know that 50% of the hospital beds in America are occupied by the mentally ill. The cost of such illness in terms of human misery, in loss of productivity and creativeness, and in sheer dollars and cents is almost beyond comprehension.

We believe a problem of such magnitude should not be a political issue. It solutions should involve all citizens. New resourcefullness and creativity should be sought. This means, among other things, that a vastly stepped up research program should be inaugurated. For such examples as polio and tuberculosis have made it very clear that research is the key to improved modes of coping with health problems. Research leads to ever more effective treatment tools. Eventually it leads to true prevention measures. It is axiomatic in the health sciences that only research leads in the long run to truly effective methods of prevention.

Note that in Colorado more than $20 million was spent last year on mental health services. Yet the percentage of total funds actually spent on research for this huge state program was a tiny fraction of one percent. Indeed, of all the western states only California, Washington, and Colorado seem to spend any state funds on mental health research. Even allowing for the twenty states in the nation which spend nothing on research, the national average-- a bare 1.7% of total mental health budgets-- is higher than Colorado's present allocation. Yet we are a leadership state in mental health!

This Task Force was set up in the Spring of 1964 to take a look at the entire field of mental health research in Colorado-- the various state departments, the universities, the treatment institutions. So complex was the task that our small group split at once into three sub-committees. Drs. Binner, Sterrit, and Wignall chaired these sub-committees and their reports appear as parts III, IV, and V. After their work, a "writing committee met with the Task Force Chairman to reconcile minor differences and plan the final report. Final writing was done by the Chairman.

I want to publicly express my gratitude to the small band of professionals who came together, with many mixed emotions, and fought thru to the objectives of this task force despite many difficulties. I want also to express our gratitude to the planning project staff-- Dr. Hans Schapire, Mr. Stanley Boucher, and Mrs. Beverly Tirva for their unstinting assistance.

Harl H. Young, Ph.D.
Chairman

II. Summary Statement of National Recommendations — and Analysis:

The summarized recommendations on Mental Health Research by the Joint Commission on Mental Illness and Health are presented below (Action for Mental Health, Basic Books, 1961, p. viii):

1. A much larger proportion of total funds for mental health research should be invested in basic research as constrasted with applied research. Only through a large investment in basic research can we hope ultimately to specify the causes and characteristics sufficiently so that we can predict and therefore prevent various forms of mental illness or disordered behavior through specific knowledge of the defects and their remedies.

2. Congress and the State legislatures increasingly should favor long-term research in mental health and mental illness as contrasted with short-term projects.

3. Increased emphasis should be placed on, and greater allocations of money be made for, venture, or risk, capital in the support both of persons and of ideas in the mental health research area.

4. The National Institute of Mental Health should make new efforts to invest in, provide for, and hold the young scientist in his career choice. The Federal government must provide, on a stable base, more salary support for mental health career investigators, more full-time positions must be established for ten-year periods as well as some on the basis of lifetime appointments, and, in the case of medical schools and universities, these latter positions must be awarded on condition that the scientist receive a faculty appointment with tenure.

5. Support of program research in established scientific and educational institutions,as initiated by the National Institutes of Health, should be continued and considerably expanded in the field of mental health.

6. The Federal government should support the establishment of mental health research centers, or research institutes. These centers or institutes may operate in collaboration with educational institutions and training centers, or may be established independently.

7. Some reasonable portion of total mental health research support should be designated as capital investment in building up facilities for research in States or regions where scientific institutions are lacking or less well developed.

8. Diversification should be recognized as the guiding principle in the distribution of Federal research project, program, or institute grants from the standpoint of categories of interest, subject matter of research, and the branches of science involved.

In addition to these broadly conceived proposals, four others are given which are somewhat more specific and have more direct relevance to the states (pp. 222-224):

First, with regard to research settings there should be support for flexible and experimental programs of stimulating research in many different areas and settings.

Second, efforts should be made to increase contacts between researchers and practitioners so as to increase mutual understanding of each other's problems and approaches.

Third, there is a general need for long-term research support.

Finally, there is an urgent need to expand and intensify basic research in mental health.

The Task Force heartily endorses all these proposals. However, certain shifts of emphasis are necessary in order to realistically accommodate certain recommendations with the existing situation in Colorado.

For example, the Commission makes a strong plea for greatly augmented funds and efforts in the areas of basic research and long-term research support. While this is laudable, the Task Force feels that in Colorado we can be more efficient by initially allocating the bulk of funds to so-called program evaluation research. Over time, and with the accumulation of knowledge regarding our <u>own</u> programs, the balance can be gradually shifted in favor of basic research. This is the sense behind our Basic Recommendations 1,5, 6, and 7. (See Summary for the summarized list of Basic Recommendations).

In order for mental health research to flourish in Colorado new administrative devices and more imaginative and cooperative arrangements between existing administrative staffs are necessary. Our Basic Recommendations 2,3,4,5, 6 and 7 are attempts to establish such new administrative devices and machinery for generating an organized and viable research program. These proposals call for a Mental Health Research (and perhaps including mental retardation) Advisory Council which would be responsible for monitoring and facilitating mental health research in Colorado — and a Planning and Research section within the Department of Institutions.

In addition to the above — the Task Force suggests we go further with such administrative innovations. For example, why couldn't a Professor of Social Work at a state supported university also hold a part-time appointment

in the Department of Public Welfare? Why couldn't arrangements be made for such joint appointments within the Federal-State support sharing principle? Why couldn't red tape be cut so that an investigator working in one state supported institution would find it an easier matter to use the computer facilities and bibliographic resources of another state supported institution? Many such arrangements are possibilities worth exploring. (See Basic Recommendation 10).

Basic Recommendations 8 and 9 speak for themselves.

In closing, the Task Force would like to make it clear to the State Mental Health Planning Committee and the citizens of Colorado that they feel Colorado already has many facilities and personnel which, if properly stimulated, coordinated and funded can serve as a nucleus for the beginning of a truly productive and viable research program. Many willing scholars hold appointments at our great universities; computer facilities are adequate; bibliographic resources are available; some clinicians, hard pressed with service responsibilities, are urgently seeking more time for research. The main ingredients lacking are imaginative leadership and funds. Can we afford not to provide these in the interests of <u>all</u> Coloradoan's mental health and personal resources?

III. Recommendations Of The Subcommittee On Financing Of Research

It was the purpose of this committee to survey the problems of financial support of research and to make recommendations on how much money the State of Colorado should spend on research and also offer some suggestions on how the money should be spent.

In approaching the problem, the committee realized that its resources allowed little more than a preliminary survey of the information available. Even without going into detailed documentation, however, it was felt that the scope and nature of the problem was sufficiently clear to be able to make reasonable recommendations on the subject.

This report is divided into three sections: a) Development of guidelines for the amount of research expenditures, b) Suggestions for spending the money available, and c) Some suggestions for research management.

Development of Guidelines

In searching for guidelines for recommending the amount of money the State should spend for mental health research, three ways of answering the question were explored: a) What figure do authorities recommend? b) What do other states spend on mental health research? and c) What do other organizations spend on research? While none of the numbers found can constitute a "correct" figure, they do give a picture of the range and magnitude of the amounts that might be considered.

What do the authorities recommend? The whole range of problems involving mental illness were comprehensively studied by the Joint Commission on Mental Illness and Health. Their recommendation (1) was that "States should be required ultimately to spend 2½% of state mental patient service funds for research." In order not to hamper already minimal service budgets, these funds should be in addition to money spent for patient care and not deducted from these funds.

What do other states spend? While 2½% seems a modest enough amount, even this minimal investment is not being made by the majority of states. The report (1) notes that "State governments which spend over $800 million annually on the maintenance of mental hospitals invest a bare 1.7% in research." If the states of Illinois, Michigan, New York and Pennsylvania are subtracted, "the remaining states collectively allocate less than 0.5% of their total mental hospital budgets (1958) for research." While things have probably improved somewhat since that date, in 1958 "more than 20 . . . states made no appropriation whatever for research."

According to information received from WICHE recently, California is the only one of the western states, other than Colorado, that has any funds for mental health research listed in its budget. In the other states in this region, such research as is supported is included in the funds for patient care or the general operation of the institution (apparently this is done in Washington, for instance). It would appear, then, that the western states have not moved much beyond 1958 in their support of mental health research.

While inquiry failed to yield any detailed figures for mental health research in Colorado, it is estimated that probably less than $100,000 or 0.5% of the approximately $20 million spent on the two state hospitals in 1964-65 was spent for research in these institutions. As noted above, this is approximately where state expenditures across the nation stood in 1958.

This brief look at state expenditures is not useful in that it supplies benchmarks for gauging proposed expenditures. It is useful, however, in that it indicates the dismal position these expenditures for mental health research enjoy -- if we might use that word -- among the states of this nation.

What do other organizations spend? The federal government is by far the largest supporter of mental health research in this country. In 1964 it spent around $92 million on research. Most of this, $89 million, was spent by the National Institute of Mental Health (10) and another $3 million was spent by the Veterans Administration (4).

Overall, including state and private funds, it is estimated that $113 million was spent on mental health research in fiscal 1963-64. With the estimated cost of mental illness in 1963 at over $4 billion, the annual research investment of this country was less than 3% of this cost (2, 13).

These figures seem huge and almost incomprehensible in terms of our personal budgets. Perhaps we can give some perspective to them by listing some of the national annual expenditures for the year 1962 (5). As a nation, we spent over $11 billion on alcoholic beverages, $7 billion on tobacco products, $500 million on greeting cards, $347 million on chewing gum, $114 million on toilet water and cologne and $86 million on hair color preparations. Many more expenditures, both larger and smaller, could be listed. The point, however, is that the expenditure in mental health research is not large by national standards -- somewhere between toilet water and hair color preparations on the list quoted.

Another way of putting these figures into perspective is to note that manufacturing companies with research and development programs spent 4.4% of net sales on R & D during 1961 (11). There were wide variations among industries with the aircraft and missile industries devoting 24% of net sales to R & D, with the petroleum, chemical and communication industries also reporting large investments in R & D. One single company, the giant DuPont Industries, budgeted "58 million a year for 'pioneering' research alone" (12).

The overall picture is that the Joint Commission recommended that the states spend 2½% of their service funds; the nation as a whole spent somewhat under 3% of the estimated cost of mental illness, while manufacturing companies spent 4.4% of net sales on research. Thus, the 2½% recommended by the Joint Commission could be taken as an initial minimal level of expenditures to research. In addition, this expenditure could be gradually increased to around 5% without overinvesting in research.

Even the minimal level of expenditure could be a problem to the State in terms of available revenues. The problem of raising revenue, is, of course, beyond the scope of the committee. It might be noted, however, that the State of Illinois raises a maximum of a million dollars a year for training and research by earmarking funds raised from patient care (8).

Note that it is not a question of whether or not to spend money on mental illness. The State's operating expense for just the two State hospitals amounted to around $20 million for 1964-65. The question is whether the State can continue to afford to spend these sums of money without investing more in research designed to find better solutions to the problem.

Plan for Permanent Staffing. One final aspect of research planning is that the core staff of each agency should be planned on a permanent basis. It is often very difficult to assemble a research staff for a project and very wasteful to let them go again only to assemble a new staff for another project. Again, from private industry, "There is no more inefficient way to spend research money than an 'on again, off again' basis which happens when research is treated as an annual budget appropriation (6)." As much as possible, these departments within an agency should be planned to grow and develop on a stable basis. Moreover, this should make staff somewhat easier to attract if a stable future can be offered and long-term projects planned with the expectation of being able to see them through.

Summary

On the basis of actual and suggested expenditures, the committee recommended that the State should spend at least 2½ % of its mental patient service funds for research.

It is also recommended: (1) That the funds be channeled through a Research Council for statewide planning, coordination and evaluation of these research activities, and (2), that the research positions be permanent staff members with sufficient supportive staffs and safeguards against service pressures.

Respectfully submitted:
Paul R. Binner, Chairman
Donald Davids
Merle Adams

IV. Recommendations Of The Subcommittee On Research Policy And Organization

It was the purpose of this committee to discuss research policy and organization and to make recommendations. The committee concerned itself with the following questions: a) What is the appropriate scope of publicly supported research activity bearing on mental health problems in Colorado? b) What public policy will best stimulate and support continuous, fruitful research into mental health problems in Colorado? c) What form or structure should research activity take within the larger structure of state government? d) What special resources are needed to facilitate coordinated mental health research activity within the state?

The Scope of Research Activity

The evaluation of the effectiveness of public mental health programs in Colorado, and the search for new knowledge about mental illness and its treatment, are major areas of appropriate concern for publicly supported research. While research in each of these areas will hopefully produce useful knowledge, research activities in the two areas must be separate and independent.

Evaluation is useful in measuring the effectivenss and efficiency of mental health programs. It yields comparative information on the efficacy of various methods of dealing with specific mental health problems, and leads to the most efficient deployment of limited resources.

"Evaluation has been defined by the American Public Health Association as ' . . . the process of determining the value or amount of success in achieving a predetermined objective' (1960). Mental health program evaluation, then, refers to the assessment of the degree of success and value in reaching predetermined mental health program objectives. This type of evaluation constitutes one of the large variety of descriptions which can be made of mental health programs and as such may be viewed as part of the larger field of mental health program analysis. Program analysis, in turn, can be thought of as one step in total program planning, since its task is to provide a wide variety of information which contributes to the decision-making processes.

"Program evaluation differs in several respects from more traditional research activities. Research activities usually exist independently of program planning, while evaluation is, by definition, interwoven with program. A research study can terminate when new facts are revealed, but program evaluation is a continuous process which both feeds into and grows out of program planning. While the audience for research studies tends to be made up of one's professional colleagues, program evaluation reports are read not only by colleagues but by a wider audience with broad program responsibilities. Thus, communication of findings presents a special

problem. At least as important as these differences, however, is a fundamental similarity between program evaluation and research, namely, that both activities demand the utilization of the accepted methods of science.

"It must be remembered that accepting the validity of a mental health program can be very costly to a community. In 1962 alone, State and local units of government in supporting programs for the hospitalization of their mentally ill, spent in excess of one billion dollars. With demand for funds and services already exceeding their availability, it is particularly important to know that the efforts being made by mental health personnel do, in fact, result in the attainment of their program objectives." (1)

Basic Research is an integral part of the long-range attack on mental health problems, and should be a part of Colorado's mental health program. It is best conducted where mental health problems are seen, in institutions and clinics, and in specific community environments.

It is in the interest of the state to support basic research in psychiatry, in the behavioral sciences (anthropolity, psychology, sociology, political science, economics) where mental health problems or data are being considered, and in germaine social work research.

Research Policy

Research policy should be directed to achieve the maximum productivity of research persons and research environments in the mental health field in Colorado. The policy should be formulated in light of our best knowledge of how research people work, and of how existing resources may best be used or developed. A realistic policy toward research is an essential foundation of continuous, coordinated research activity. A realistic policy will consider the following in reference to research persons and research environments:

Research Persons are a rare breed in many ways. They are scarce. They have devoted much time and money to their professional training. They work with a sense of urgency, and place a high personal value on their time. They are independent. Their work schedules are often different from the work schedules of others in the organizations where they work. In order to work effectively, they need freedom to structure their own work environment, and support in obtaining the materials and facilities they require, with a minimum of delay and frustration. They need to be supported, encouraged, and let alone.

Research Environments in state supported institutions and agencies, by the nature of their being structured to meet primary service goals, are not structured for research. Adaptive mechanisms must be used if the researcher is to effectively work in and contribute to his research

environment. He must be exposed to it, yet be protected from it. It must be exposed to him, yet protected from him. The research environment is dangerous to the researcher, in that it may demand so much compliance to its own work-ways, and demand so much service, that the researcher is absorbed by the enviornment. The research environment must be protected from the researcher, by guarantees that agency confidentiality will not be violated, and that the researcher will not become an agent through which the environment can be improperly manipulated.

Adaptive Mechanisms: If there are no pre-arranged mechanisms whereby the researcher can work autonomously in the research environment, conflict is likely to arise. The researcher will request non-routine services, which the institution or agency is not structured to provide. The agency or institution will defend itself by isolating and denying the researcher; or will invite the researcher to accommodate to the point that he cannot work effectively as a detached observer.

The adaptive mechanisms should be an outside administrative support, geared to evaluate and meet the non-routine needs of the researcher for materials and services; but one which is not involved in the administration of mental health service programs. This outside administrative support should have the triple function of: a) protecting and supporting the researcher in his environment, b) protecting the research environment from improper outside manipulation through researchers, and c) providing professional evaluation of research activity. This outside support can best come from a Research Council adjunctive to the Director of the Department of Institutions.

The Research Council would be a professional body, representative of researchers within the Department of Institutions, augmented by representative research professionals from universities, and other public and private agencies. It would foster academic freedom and professional responsibility for research programs within the Department of Institutions. It would serve to protect the Department of Institutions from sub-professional research performance, and protect researchers from non-professional evaluation of their activities. Being an independent advisory body, the Research Council would be free from untoward pressures within state government. It would not, in itself, abrogate administrative authority prejudicial to the academic freedom of researchers within the Department of Institutions.

Organizing Research Activity Into The Larger Structure of State Government

Mental health research activity should be organized within the larger structure of state government according to the following principles:

A. An Advisory Council on Mental Health Research should be established to assist the research activities of all agencies of the state which deal with problems of human health and disorders.

B. A Research and Planning Section should be established in the Department of Institutions, to provide specified services to appropriate mental health research activities.

C. The Advisory Council would provide consulting service to the Colorado State Civil Service Commission, and to the directors of agencies and institutions, in assessing the suitability of applicants for mental health and other behavioral science positions.

D. The Advisory Council would provide consulting service to Departmental Directors to advise about the value of research projects, or the competency of researchers, should such questions arise.

E. Continuing research programs should be maintained by the various institutions and agencies of the Department of Institutions. Research personnel should be employed by the various institutions and agencies. Other researchers should be attached to special projects operated through the central office of the Department of Institutions. Supplementary budgets for specific research activities should be available through the Research Support Section.

F. The Research Council should be empowered to act as administrator of grants-in-aid to individual research programs, permitting greater flexibility in the use of grant funds.

G. The Research Council should sponsor seminars, professional meetings, and other activities which would permit researchers to share ideas, and to informally coordinate the research activity within the Department of Institutions.

H. The Research Council should sponsor high-level professional meetings to enhance the continuous development of professional research skills. It should not duplicate the research training effort of colleages and universities at the pre-professional level.

I. Individual research programs should attempt to provide some pre-professional research experience for college and university students.

Milton Lipitz
Nancy Wertheimer
Carl Zimet
Clifton Wignall, Chairman

V. A Proposal to Create a Colorado Advisory Council on Research In Mental Health

It is proposed that a Colorado Advisory Council on Research in Mental Health be created for the purposes of stimulating and facilitating research bearing on mental health problems in Colorado.

The Council could have as its primary responsibility the study of ways to get and keep the best research people in Colorado, people who can develop existing lines of research and create new research toward the solution of pressing mental health problems. Excellent research is the product of excellent researchers, and no activities of the Council could have more powerful effects than efforts aimed at recruiting and keeping researchers of the highest caliber.

Gaining and holding the best researchers depends upon creating a climate that facilitates research. The Council might be active toward this end in many ways, of which the following are only a few examples:

First, after appropriate study, the Council might recommend certain guide lines for the state to follow in the expenditure of funds for research. For example, the Council might wish to suggest that, in general, the expenditure of a given sum of money for the acquisition of a higher caliber investigator is a sounder investment than money spent for the support of a particular project. This is because the high quality researcher will attract significant sums from major federal and private granting agencies for the conduct of more than on sizeable project. Moreever, the presence of one excellent researcher makes it substantially easier to recuit a second.

Such a recommendation might lead to the creation of research positions in various institutions initially on a limited basis, e.g., three or four. These research positions could be of several types. For example, a single researcher might serve several mental health clinics in conducting comparative program analyses. Or, a researcher interested in basic studies of the nature of schizophrenia, our most prevalent and serious mental disorder, might be located at one of the major state hospitals. Still another arrangement might permit a capable researcher to work closely with the juvenile courts or within the public schools in the interest of preventive studies.

A related question which the Council might study is the future desirability of a centralized research institute in Colorado, to house, on a full or part time basis, a variety of mental health researchers. The

potential stimulation to better investigation inherent in such a physical arrangement offers significant advantages. Federal funds might be obtained to aid in building and staffing such a facility.

Second, the Council could attempt to identify specific beliefs and attitudes that tend to block acceptance of mental health research among the general public, but also in the legislature, the public schools and even in our clinics and institutions. Special attention might be given to the misbelief that research is opposed to or uninterested in practical efforts. Kurt Lewin observed that "there is nothing more practical than a good theory." This message needs wider circulation! The incidental economic benefits to Colorado, resulting from more and better mental health research, could be more widely publicized. The national expenditure for research in mental health amounts to many millions of dollars annually. Every project which brings a larger share of these funds into Colorado benefits the economy of the whole state and region. Mental illness is costly and research which helps return our mental patients to normal life converts Colorado tax users into Colorado tax payers. Above all, however, the public should be made aware of the fact that mental health researchers are primarily interested in the very practical goal of helping to alleviate some of the most prevalent and least well understood sources of human misery.

The Council could find and recommend ways of making the state's and region's research resources known to present and potential researchers. The Council might wish to recommend a state wide survey for this purpose, perhaps publishing the results of the survey as a "Handbook for Mental Health Researchers in Colorado." The state's institutions of higher learning house a number of centers of professional and technical knowledge which are available to researchers for consultation. Not all of these centers are known to everyone at present. For example, many in the state may be unaware that the Laboratory of Statistics at Colorado State University has recently expanded and is now reorganized as one of the best in the nation, or that a Laboratory of Animal Resources is planned in Fort Collins which will supply standardized animals as well as the most expert consultation on all phases of research with animals.

Along the same lines, the Council could study the problem of how to facilitate liaison between the individual researcher and agencies that might provide settings or subjects for his research. The University faculty member who has an idea for a clinical study may not know the most appropriate sources of patients of the kinds that his work requires. His request for help may receive unsympathetic treatment if it goes to someone burdoned with the service pressures of a clinical setting unaccustomed to accommodating researchers. The Council might set up lines of communication which would assist and facilitate the individual researcher in such instances.

The public schools have presented several as yet largely unexplored opportunities and unmet challenges for the mental health researcher. With the increasing focus in psychiatry and clinical psychology on studying the early determinants of maladjustment, and with more emphasis on understanding

and strengthening the healthy, adaptive forces in personality, as opposed to uncovering pathology, there is more and more interest in the school age child and in his functioning in the school situation. Schoolrooms are appearing in treatment centers and psychologists are more and more prevalent in the schools. Psychological research in the school setting promises better understanding of normal behavior as well as early identification and prediction of maladaptive behavior. At the present time, however, the role of the psychological researcher in the school setting is ambiguous and difficult. Fears have been expressed about having school children "experimented upon", and exposure to projective test materials and family adjustment questionnaires have been threatening to some parents and educators. The Council could study this problem carefully and might wish to create a special task force to guide and facilitate the trend toward closer relationships between the mental health researcher and the public schools, so that real obstacles to cooperate might be overcome and unreal ones recognized as such.

At present a small percentage of the state funds allocated to institutions and agencies to meet service needs are earmarked for the purpose of self-evaluation. This is a very important kind of research which the state could support and is likely to be willing to support. It has been suggested that at present, funds are not always used for this purpose, or are used ineffectively. The Council might play a helpful role in this area. Probably some settings that do not evaluate their own activities might best avoid self evaluation -- the analogy has been made to asking a typist to report on what the fingers are doing, the effect of which is to disorganize what may have been an obviously very smooth-running and effective operation. But in those settings in which self evaluation is wanted, the Council might offer general or specific directions as to how to proceed suggestions as to appropriate consultants, etc.

The Council might also wish to recommend periodic appraisal of the self evaluations made at various state supported mental health institutions and agencies. This might best be carried out by experts from other states, selected from a list provided by the institutions and agencies to be appraised. It might also be wise to put participation in the appraisal on a voluntary basis, so that agencies that are just getting started or are in a transititonal phase might be able to concentrate all of their resources on carrying out plans in progress, saving self evaluation for more stabilized periods of operation.

In general it would seem well to advise that the Council maintain a positive and helpful role in relation to present and potential researchers, and that it particularly avoid becoming a gatekeeper or the champion of any particular theoretical or methodological viewpoint.

It appears best that the Council not be located within any existing State Department, since each of the five relevant State Departments has an interest and should have equal chance to be heard by the Council.

Council members might be asked to serve one day per month. The Council's paid staff might consist of one executive secretary, who would have responsibility for recording minutes of Council meetings, carrying on Council correspondence and planning and carrying out surveys and special studies as recommended by the Council.

The issue of whether the Council or any arm of the Council should receive and disburse funds, other than those mentioned in the preceeding paragraph, needs further study. The State will never be in the position to offer grants for mental health research on a scale remotely approaching that of the National Institutes of Health. It is possible that small grants from the State or from a foundation established from private contributors administered by the Council, might be used for purposes not covered at present by the National Institutes of Health. For example, demonstration research projects will be supported only for a limited time by federal funds. Worthwhile projects in this category could be picked up with state funds. Similarly, state funds might be used to support worthwhile research in settings which would not be likely to qualify for NIH support (e.g., in smaller clinics and agencies unaffiliated with Universities or other prestigeful institutions).

It is possible, however, that research goals might be achieved more effectively by means other than direct state monetary support. For example, the Council might create a committee to review local research proposals not for the purpose of granting funds, but to find ways of creating institutional affiliations that would allow successful application for NIH funds, or to aid individuals to find alterative sources of support for worthwhile projects not supportable by NIH. Such activities might prove much more beneficial to researchers in Colorado than meager direct support from state funds.

Graham M. Sterritt, Chairman
Doris Gilbert
Kenneth Purcell

The names and pertinent data regarding the members of the Task Force are presented below:

Merle Adams, Ph.D.
Department of Sociology
University of Colorado

Paul Binner, Ph.D.
Assistant Chief Psychologist
Fort Logan Mental Health Center

Stanley W. Boucher, A.C.S.W.
Assistant Director
Mental Health Planning Project
State Department of Institutions

Don Davids, Chief
Records & Statistics Section
State Department of Public Health

Doris Gilbert, Ph.D.
Director, Child Center
University of Denver

Hiram Gordon, Ph.D.
Psychology Service
Ft. Lyon V.A. Hospital

David Kaplan, Ph.D.
Director, Psychiatric Social Service
University of Colorado Medical Center

Milton Lipetz, Ph.D.
Department of Psychology
University of Colorado

David Metcalf, M. D.
University of Colorado Medical Center

Paul Polak, M. D.
Director of Research
Fort Logan Mental Health Center

Kenneth Purcell, Ph.D.
Director, Psychology Service
Jewish National Home for
Asthmatic Children

Hans M. Schapire, M. D.
Director, Mental Health
Planning Project
State Department of Institutions

Ozzie Simmons, Ph.D.
Department of Sociology
University of Colorado

Graham Sterrit, Ph.D.
Research Psychologist
University of Colorado
Medical Center

Kayo Sunada, M. D., Director
Clinical Services
State Home & Training School
Wheatridge, Colorado
Chairman, Mental Retardation
Task Force

Nancy Wertheimer, Ph.D.
Research Department
Fort Logan Mental Health Center

Clifton Wignall, Ph.D.
Research Sociologist
Colorado State Hospital

Harl Young, Ph.D.
Clinical Psychologist

Carl Zimet, Ph.D.
Chief, Psychology Service
University of Colorado
Medical Center

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TASK FORCE ON PSYCHIATRIC CASE REGISTERS:

Possibly the most technically focused of all task forces, this group was set up to examine the feasibility of establishing electronic case registers in all or a portion of Colorado. The case register concept has stirred epidemiologists and administrators alike ever since development of the computer seemed to make it feasible and economical. A register would measure the true input of psychiatrically disturbed persons in any given year into the mental health service-system available to a given community. For the first time, valid studies could be made on the number and types of mentally ill who become new admissions, where they go, how many and what kinds are re-admitted later, etc. To study this problem, a seven man group was put together under the chairmanship of Dr. Brenda Dickey, Ph.D., a social psychologist at Fort Logan Mental Health Center. Also serving were Dr. Ray Lewis, M. D., a Fort Logan psychiatrist (and chairman of a regional mental health committee in Boulder); Dr. William Robinson, M. D., of Denver General Hospital; Dr. Henry Welch, Ph.D., Director of the Metropolitan Council For Community Service; Mrs. Lois Burrell from Denver Department of Public Welfare, Mr. H. Wayne Sheller, R.R.L., from Colorado Psychopathic Hospital; and Stanley Boucher of the Planning Project Staff.

Summary of Recommendations:

1. Case registers are an enormously promising research tool -- and possibly useful for more efficient management of treatment on a multi-agency basis.

2. However, the problem of confidentiality would have to be solved by extremely diligent negotiation -- and probably legislation -- so as to ensure that no information of a private or confidential nature was accessible to any outside person. Such a problem might be resolved merely by guaranteeing rigid standards of professional integrity for those with access to a register. But it might have to be solved similarly to the State of Maryland (where no information for the management of individual cases may be returned even to agencies sending data into the central register).

3. If a register is legally feasible, its use could lead not only to major gains in scientific understanding of the causes and natural course of emotional disorders but more efficient allocation of treatment resources and economic analyses would also be feasible. The committee believes that in the long run, a register would pay for itself in the same manner as investment in quality controls yields dividends to industry.

4. Recent advances have been made in the technology and implementation of automatic data processing in the field of mental illness. Even in registers of limited patient coverage, such as the Fort Logan Record System, there is substantial evidence to suggest that the present constitutes a particularly fortunate time to undertake detailed planning for a case register in Colorado. Maryland's and New York's experience in this regard are exemplary.

5. The membership of the Ad Hoc Committee was composed of representatives from many of the types of agencies who would be potential contributors supporting such an endeavor and thought that their own great interest was an index of the favorable support that a properly designed and executed register would meet.

6. The Committee urged that impetus for planning and developing the register come from the State. The Department of Institutions or some subsection of the Department was mentioned as the specific locus for this responsibility.

7. The Committee also made several specific recommendations regarding the content and management of the register's data:

   (a) That the register's subject coverage initially be narrowly defined in order that the problems of attaining the foregoing purposes be thoroughly explored and solved.

   (b) That the long-range content of the register's cases should be related to the general area of social disorder and mental health. The suggested area for pilot work, however, is that of a restricted subsection of this problem, but the area should cover as fully as possible <u>all</u> cases coming within its definition. This standard seems extremely vital to meet if the register is to approximate a useful epidemiological tool. It is also vital for satisfying the other values associated with operational (administrative) research.

   (c) Suggested content areas are as follows: existing registers on juvenile delinquency or alcoholism. The third possibility is the proposed War on Poverty register, which has already received tentative promises of Federal support. Because of the national as well as local urgency of the particular problem area covered under this plan, the War on Poverty Register seems, in the Chairman's opinion, to constitute an excellent area for a pilot project.

   (d) That the Denver area, or some portion of it, be the geographical territory encompassed by the register.

   (e) That if the register is not automated in the beginning, automation should be used as soon as possible.

Finally, the Committee cannot over-emphasize the importance of maintaining agencies' involvement and interest in the register. Planning and funding should insure that this need be satisfied. It is probable that some staff person (or persons) should be hired for this explicit purpose. These individuals could also help insure that the register be planned to (a) provide answers for contributors' administrative planning questions, and that (b) means be devised to provide adequate feedback of these answers to information contributors.

State of Colorado Mental Health Planning Project

Ad Hoc Committee on Case Registers

FINAL REPORT

Epidemiology is not widely understood, either as a science or as a methodology. Even though mental health planners and researchers have a vague understanding of its usefulness in studying the spread of infectious diseases, relatively few have been exposed to the applicability of epidemiological methods in mental illness. Perhaps the best explanation is provided by Reid (1960):

> "Epidemiology has been variously defined. . . In medicine in general, and in psychiatry in particular, the limitations imposed by a preoccupation with the individual patient unrelated to his social or physical environment have become increasingly obvious in recent years. . . Since many mental illnesses are as much 'crowd diseases' as is typhoid fever, the epidemiological method evolved for the study of infectious disease applies equally to the investigation of the individual's reaction to his surroundings and of the varied patterns of mental disorder in different or changing social or other conditions.
>
> "In psychiatry, as in other branches of medicine, epidemiological inquiry is designed to measure the risk of attack by specific disorders within communities and to uncover clues about their origin and mode of spread. These clues are gleaned from the distribution of disease in relation to time, space, or the distinguishing characteristics of the individuals or social groupings affected. Once the natural history of the disease in a particular population has been established, the epidemiologist is concerned to devise measures of disease prevention or control and to assess their efficacy in practice. Successful prophylaxis achieved by modifying some essential cause is the ultimate test of the epidemiological approach; and a creditable series of such successes has made epidemiology the basic science in preventive medicine. . .
>
> "The first step in this system of disease investigation is a process of description whose essential feature is the comparison of the incidence of a specific abnormality in sub-groups of human populations. This implies the observation of such groups over a period of time, noting the rate of onset of a defined syndrome among people differing in environmental circumstances and personal

habits or characteristics. In practice, however, the comparisons must often be restricted to the prevalence of the disease in particular groups, i.e., the number of cases existing in the population at one point in time. Whatever the technical method, the aim is identical: to see whether the risk of becoming ill is greater among groups of individuals with some characteristics, personal or environmental, in common than in others not exposed to the specific environmental circumstance or without these particular attributes." (Reid, 1960, pp. 8-9. Italics added).

Epidemiological approaches presuppose that a means exists or can be devised for finding the cases having the condition to be studied. In mental illness, large scale surveys have been used frequently: Hollingshead and Redlich's New Haven research is but one of the more familiar examples of this technique. The difficulties of identifying cases in such a manner are obvious -- the cooperation of large numbers of diagnosticians trained to recognize the illness, the time and expense involved in collecting, processing and analyzing the data. And before these steps are completed, a geographical area must be defined and the sampling techniques specified. The italicized portion of Reid's quotation above merely serves to emphasize the fact that because of these problems, prevalence measures must often be substituted for the scientifically more desirable incidence statistics. And in many researches, prevalence is further restricted by a narrow time segment: the number of cases of psychoses in a state's institutions at the end of a fiscal year in relation to the state's population is an example of a prevalence ratio.

Changes in numbers of cases in such prevalence ratios are later compared. Inferences from the changes sometimes imply that the incidence of a condition has increased, or perhaps decreased. However, even if the investigator is using only "first admissions" to the state's institutions, he can easily forget that a first admission to State Hospital A may have been a first admission five years ago to Outpatient Clinic B.

In 1964 there were seven major psychiatric case registers in existence. They were:

MARYLAND

Population covered: Residents of State (3 million).

Objectives and special interests: Research and planning; development of methodology (statistical, electronic, epidemiologic).

Reporting status: Started July 1, 1961; data for July 1961 to be tabulated by December 1, 1962.

Volume: Initial rolls, 18,000 (estimated); accretion first year, 10,000 (estimated); admissions, 20,000 (annual).

Present psychiatric facilities: All facilities, including District of Columbia; State, Veterans Administration, private and general hospitals; state and non-State institutions for mental defectives; State, Veterans Administration, and community clinics.

Projected extention: Private psychiatrists, social agencies.

Followup data: All hospital patient movement, death clearance, migration.

HAWAII

Population covered: Persons provided service by State division of mental health, except mentally retarded (600,000).

Objectives and special interests: Program planning and evaluation, special emphasis on individual patient movement and treatment; research application.

Reporting status: Started November 1, 1961, 6-month trial run completed; reporting forms and procedures being modified.

Volume: Initial rolls, 3,000 (estimated); accretion first year, 3,000 (estimated); admissions, 3,000 (annual).

Present psychiatric facilities: State, general (medical indigents only), and chronic disease hospitals; State clinics.

Projected extension: All clinics, general hospitals, Federal facilities, private psychiatrists, nursing homes.

Followup data: All patient movement.

UPSTATE COUNTY, N.Y.

Population covered: Residents of county, except mentally retarded (600,000).

Objectives and special interest: Epidemiologic research and planning; special interest in treatment.

Reporting status: Started January 1, 1960; data tabulated for January 1960 and year 1960.

Volume: Initial rolls, 5,000; accretion first year, 5,000; admissions, 12,000 (annual).

Present psychiatric facilities: State, Veterans Administration, general, and county hospitals; State, Veterans Administration, and community clinics; private psychiatrists.

Projected extention: None.

Followup data: Every 3-6 months while under care; death clearance; migration.

WASHINGTON HEIGHTS, NEW YORK, N.Y.

Population covered: Persons whose clinical records list them as residing in Washington Heights Health District (270,000).

Objectives and special interests: Epidemiologic research; reference register for Columbia-Presbyterian Medical Center.

Reporting status: Started April 1, 1956; data tabulated through March 31, 1960.

Volume: Initial rolls, 2,300; accretion, routine 450 (annual); partial accumulation, 1,450; register total, 5,100.

Present psychiatric facilities: Routine--State and non-State hospitals; State and non-State institutions for mental defectives; State and Manhattan aftercare clinics. Partial--Bellevue Hospital; Vanderbilt Clinic of the Presbyterian Hospital.

Projected extension: Veterans Administration facilities; clinics; general hospital.

Followup data: All hospital patient movement.

DUTCHESS COUNTY, N.Y.

Population covered: Residents of county, except mentally retarded (170,000).

Objectives and special interests: Epidemiological research; service evaluation, small facility versus large State hospital; study of chronic disability and remission.

Reporting status: Started January 1, 1960; no tabulation as yet.

Volume: 3,000 (incomplete); estimated total when complete, 12,000.

Present psychiatric facilities: State hospital; day care center; clinic.

Projected extension: Veterans Administration Hospitals; private institutions; private psychiatrists; general hospitals; general practitioners.

Followup data: Annual, whether under care or not; death clearance; migration.

MONTEFIORE HOSPITAL, NEW YORK, N.Y.

Population covered: Health area in Bronx County, N.Y. (31,000).

Objectives and special interests: To formulate and carry out clinical demonstration of community mental health services; special interest in epidemiology, longitudinal studies, and social psychiatry.

Reporting status: Started July 1, 1960; data tabulated for March 31, 1962.

Volume: Initial rolls being completed; accretion, 300 (first year); admissions, 500 (annual).

Present psychiatric facilities: State and general hospitals; general hospital, State, and Veterans Administration clinics; health area school; medical group; community center.

Projected extension: City hospitals, private psychiatrists, social agencies.

Followup data: All patient movement, periodic review, migration.

NEW YORK, N.Y. (Narcotics addiction)

Population covered: Addicts in New York City.

Objectives and special interests: An unduplicated count of narcotic addicts in New York City; evaluation and epidemiologic research; description of services offered by health department facilities; degree and type of service.

Reporting status: 6-month trial began September 1, 1962.

Volume: The estimated 25,000 or more narcotic addicts in New York City.

Present psychiatric facilities: All facilities in New York City; State, municipal, voluntary, and proprietary hospitals; State, municipal

and community clinics; New York City Department of Health neighborhood demonstration programs.

Projected extension: Social agencies; voluntary neighborhood groups; private psychiatrists, physicians, and psychotherapists.

Followup data: Death clearance; patient movement.

The attributes of these registers point to their usefulness for operational as well as epidemiological research. The 1962 Psychiatric Case Register Conference (Bahn, 1962) commented that "clinicians and administrators want to determine the answers to a series of questions: What are the needs and the fate of prognosis of a patient population? How large is the patient population? How long is the typical treatment period? Is treatment provided in two or three different facilities or in only one? If the former, what is the sequence of care? What proportion of the time is spent in an institution? Does the patient spend long intervals at home or does he go rapidly from one institution to another? What happens to the individual who drops out of clinic care -- is he likely to return to a psychiatric facility?" (p. 1072)

The technical problems of handling such masses of information even when the geographical territory covered by the register was extremely small were, until recently, enormous. With the development of automatic data processing equipment, some solutions seemed nearer at hand. However, the existence of these new armamentaria has still failed to insure the existence of some registers long enough for them to contribute meaningfully to research in the epidemiology of mental illness.

In discussing the epidemiological and operational benefits of a psychiatric case register, the Committee expressed pessimism over the fact that many earlier registers have been abandoned. While lack of funds has been cited as an ostensible reason, the main underlying cause is also directly related to the register's failure to enlist the cooperation and, more importantly, the interest of its contributors. Token cooperation can be guaranteed by legislatively requiring agencies and institutions to contribute certain data periodically to the State or Federal government, but this cooperation certainly does not insure getting valid, useful information. Even when the register's planners have tried to enlist interest by promising answers to the foregoing question, provision apparently was not made for either collecting the kinds of information that would serve these purposes, or program planning did not include the means whereby the answers actually could be fed back to the appropriate administrators. Thus, while poor financial support for research into adequate planning for, and prevention of mental illness is a legitimate complaint, maximal funding for a case register could still produce a highly unsatisfactory case identification tool.

In the course of exploring the preceding advantages and pitfalls of a register, a questionnaire was sent to the Committee members and their

opinions individually elicited. The questionnaire and results are appended for their interest. These expressed opinions were used in the final discussion of the Committee's recommendations which are summarized below.

RECOMMENDATIONS

1. Research into the prevention of mental illness is a publicly admitted field of critical importance, not only for the nation but for individual states as well. The advisability of establishing a case register in Colorado should not be minimized because a register could provide the means of gaining much-needed knowledge about the epidemiology of mental illness.

2. Research in mental disorder, however, has suffered from lamentably meager financial support in the past. The Committee felt that adequate funding of a case register could lead not only to gigantic gains in our scientific understanding of mental illness, but could also lead to more economical planning for the future resources needed to handle this wide-apread health problem. More extensive spending in this are now can be expected to lead to greater savings later.

3. Recent advances have been made in the technology and implementation of automatic data processing in the field of mental illness. Even in registers of limited patient coverage, such as the Fort Logan Record System, there is substantial evidence to suggest that the present constitutes a particularly fortunate time to undertake detailed planning for a case register in Colorado. Maryland's and New York's experience in this regard are exemplary.

4. The membership of the Ad Hoc Committee was composed of representatives from many of the types of agencies who would be potential contributors to a psychiatric case register. They recognized the necessity of contributors supporting such an endeavor and thought that their own great interest was an index of the favorable support that a properly designed and executed register would meet.

5. The Committee urged that impetus for planning and developing the register come from the State. The Department of Institutions or some subsection of the Department was mentioned as the specific locus for this responsibility.

6. The Committee also made several specific recommendations regarding the content and management of the register's data:

(a) That the register's subject coverage initially be narrowly defined in order that the problems of attaining the foregoing purposes be thoroughly explored and solved.

(b) That the long-range content of the register's cases should be related to the general area of social disorder and mental health. The suggested area for pilot work, however, is that of a restricted subsection of this problem, but the area should cover as fully as possible all cases coming within its definition. This standard seems extremely vital to meet if the register is to approximate a useful epidemiological tool. It is also vital for satisfying the other values associated with operational (administrative) research.

(c) Suggested content areas are as follows: existing registers on juvenile delinquency or alcoholism. The third possibility is the proposed War on Poverty register, which has already received tentative promises of Federal support. Because of the national as well as local urgency of the particular problem area covered under this plan, the War on Poverty Register seems, in the Chairman's opinion, to constitute an excellent area for a pilot project.

(d) That the problem of confidentiality be thoroughly investigated before the register is instituted.

(e) The the Denver area, or some portion of it, be the geographical territory encompassed by the register.

(f) That if the register is not automated in the beginning, automation should be used as soon as possible.

Finally, the Committee cannot over-emphasize the importance of maintaining agencies' involvement and interest in the register. Planning and funding should insure that this need be satisfied. It is probable that some staff person (or persons) should be hired for this explicit purpose. These individuals could also help insure that the register be planned to (a) provide answers for contributors' administrative planning questions, and that (b) means be devised to provide adequate feedback of these answers to information contributors.

Brenda A. Dickey, Ph.D., Chairman
Ad Hoc Committee on Case Registers

THE TASK FORCE ON MANPOWER: An Interim Report

Manpower is not only an obvious and crucial aspect of mental health planning, it also lurks as bugaboo number one in the background of every discussion of mental health needs and how to meet them. The shortage of manpower -- at least to meet projected needs with the methods and staffing patterns of the past -- is absolute and probably permanent. Even when one reviews with satisfaction the fact that from 1950 to 1960, mental health workers across the nation increased from 12,000 to 44,000 (a 350% increase!)[1], not a single state felt that it was even close to meeting its theoretic needs.

When the task force on manpower held its first meeting in early summer of 1964 under the chairmanship of Dr. Herbert S. Gaskill, Chief of the Department of Psychiatry at the medical school, it held no illusions that it would be able to sweep away these problems with a few recommendations. However, Colorado was held to have several advantages over other states its size. First, it has a number of training institutions of its own. It plays a direct role in increasing the nation's supply of mental health professionals. Second, experience has shown that a modern mental health program, when combined with Colorado's other natural advantages in climate and terrain, attracts personnel from other states. This may not be good for the other states (except perhaps to spur them on to better their own programs!) -- but it is an undeniable advantage here and goes far to explain our recent ability to increase staff at Colorado State Hospital at the same time that recruitment for a brand new facility at Fort Logan was being undertaken.

Unfortunately, obtaining and analyzing the necessary data for this group took much longer than for any other task force. Besides two questionnaires of its own, data had to be awaited from three other questionnaires developed for the regional planning committees. Meeting in June, 1965 (with some of the first completed analyses of data finally in its hands), the group agreed that a continuation of its work should proceed on into the next year. It was even suggested that a permanent committee representing the major training institutions and treatment facilities might prove useful.

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[1] Testimony of Dr. Stanley Yolles, Hearings on H.R. 2985, 89th Congress, p. 55.

Initial strategy:

At the first meeting, Dr. Gaskill pointed out that it was no secret that there was a shortage of trained manpower in the field of mental health. WICHE, on whose manpower committee Dr. Gaskill has long served, had first pointed out the critical shortage throughout the western states nearly a decade before. A number of innovations had been sponsored since then -- for example, the summer work-study program in which college undergraduates are given a chance to work in mental health settings for the summer in the hope that they can be attracted to the field as a career. But it is generally too early to know how effective these measures will be.

It would be worthwhile, he felt, to examine the current rate at which professionals are being turned out in Colorado. It would also be useful to ascertain how many stay in Colorado. Basic policies among the various training institutions might well be reviewed as well as the possibility that the state's treatment centers might play a more effective role in helping the training process. Other members suggested "continuation education" might be investigated, both in the sense of post-graduate education for allied professions such as non-psychiatric physicians and in the sense of periodic up-dating of the skills and knowledge of mental health professionals themselves. A final extremely important suggestion was to investigate the degree to which lesser trained persons could be utilized in future treatment settings -- the so-called case aides, A.B. degree "mental health workers," trained volunteers, or even the "indigenous non-professional" coming to the fore in some of the war-on-poverty efforts.

Data Collected: A Brief Summary

I. "Needs" Vs. Available Supply

We start from the simple and move toward the complex. Table I shows the actual deployment of manpower in state-aided community mental health clinics as of June 30, 1964. Hours per year for each discipline are reduced to "persons" (i.e., 2,000 hours per year is assumed to be the equivalent of one full-time person). The total composite "persons" staffing nineteen clinics are found to be 55.4 people. Of these, 11.1 are psychiatrists, 16.7 are psychologists, and 27 are social workers.[2] The

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[2] These totals compare favorably with USPHS figures which list the equivalent of 25.3 psychiatrists, 25.8 psychologists, and 40.2 social workers in 25 clinics. These figures, of course, include one VA clinic, two out-patient clinics at the medical school, and three student health service clinics. Staff for the medical school clinics are included in the hospital figures for CPH in Table III. The out-patient hours given by medical school staff are estimated at 65,000 hours per year, or the equivalent of 32.5 persons (many of whom are trainees).

State Mental Health Planning Committee estimates that every 50,000 persons should be served by one full-time outpatient team (one psychiatrist, one psychologist, two social workers). Hence, the final column of Table I depicts the percent of this minimum need which is met by the various mental health regions in Colorado. In the next to the last column it is found that 175.3 staff persons would enable this state to meet its minimum community mental health clinic needs. This breaks down to a need for 33 additional psychiatrists, 27 additional psychologists and 61 additional social workers.

A second way to estimate need is to query existing clinics and hospitals to determine current staffing patterns and the estimated need in the next three years for additional personnel. A questionnaire was sent to some 800 agencies and 353 replies were tabulated (see Table II). There is reason to believe that the bulk of all mental health agencies in Colorado were included among the 353 as special efforts were made to get replies from all clinics, state hospitals, private psychiatric hospitals, and general hospitals with psychiatric wards. A total of 310 full-time psychiatrists, psychologists and social workers were identified as working in mental health settings. In addition, 473 nurses were so identified. The same tabulations resulted in the following estimates of need for additional full-time personnel in the next three years.

(A) 57 additional psychiatrists
(B) 57 additional psychologists with a Ph.D.
(C) 25 psychologists with M.A.'s
(D) 122 additional social workers.

This amounts to a need for 261 additional psychiatrists, psychologists, and social workers in three years -- or an annual increment of 87. The need for additional nurses, 259, is an annual increment of 86.[3]

Yet another way to estimate need is to utilize various national estimates, many made in testimony concerning comprehensive mental health centers. NIMH estimates that there are now 7 psychiatrists per 100,000 people -- by 1970, there will be 11 per 100,000. Colorado has now 165 psychiatrists, a ratio of 8 per 100,000.[4] If we are to keep pace with the

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[3] Note that non-mental health settings (such as colleges, school systems, public welfare) hoped to recruit an additional 17 psychiatrists, 32 psychologists, and 99 social workers! Perhaps this underscores the need for mental health agencies to share their staff via consultation with allied agencies.

[4] Estimates by Colorado District Branch of APA, June, 1965.

national average, we shall need 230 psychiatrists in 1970, a 39% increase. This need for 65 new psychiatrists compares fairly closely with the questionnaire estimate of 57-74 noted above and depicted in Table II. It will require a yearly increment of 13.

In testimony before Congress in 1963 and again in 1965, Secretary Celebrezze estimated that an ideal comprehensive community mental health center serving 100,000 people would have the following staffing pattern:[5]

6 psychiatrists
4 psychologists
6 social workers
14 nurses
24 psychiatric technicians

Leaving aside technicians, this would mean that Colorado would need 132 psychiatrists, 88 psychologists, and 132 social workers, a total of 352, if all its population were served by comprehensive centers. It would need 308 nurses. This would amount to a need for 660 additional mental health workers.

Of course no state can reasonably hope to staff comprehensive centers serving its entire population in just five years. But Dr. Stanley Yolles, Director of the National Institute of Mental Health, estimates that there are 64,000 mental health workers in this country as of 1965. By 1970, there will be 87,000.[6] Thus 23,000 will enter the field in the next five years -- and 22,000 will be needed to staff hoped-for comprehensive centers.

Colorado has almost exactly one percent of the nation's population. We should have, then, according to Yolles' estimate, 640 mental health workers now. By 1970, we should have 870, a 36% increase. (Hopefully, 220 of these would be involved in comprehensive centers).

How many "mental health workers" do we now have?

According to Table II, the questionnaire tabulation, we now have 783 such workers (22% higher than the Yolles estimate above). Data

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[5] Testimony of Secretary Celebrezze on H.R. 2985, 89th Congress, p. 48.

[6] Op. cit., p. 55.

collected for the Colorado Plan for Construction of Comprehensive Mental Health Centers (summarized in Tables III and IV) reveals a total manpower deployment in psychiatric hospitals, both public and private, of 108 psychiatrists, 51 psychologists, 100 social workers, and 390 nurses. This totals to 649 workers. If this relatively hard data is combined with that from Table I, staffing in public mental health clinics, we get a total as follows:

Total:		Public Sector Only:
119.3	psychiatrists	95.8
67.2	psychologists	64.7
127.0	social workers	127.0
390.0	nurses	285.3
TOTAL: 703.5		572.8

This total of 704 is only 10% above the Yolles average estimate of 640. It leaves out most private practice psychiatrists since private hospitals generally listed only full-time staff members rather than those who have staffing privileges. If we accordingly substitute the known total of 165 psychiatrists for the figure given above, the total number of "mental health workers" known to be active in Colorado becomes 749. If we similarly add certified clinical psychologists (who total 164) in place of the figure above, the grand total of mental health workers becomes 846.

Of these, 573 are identifiably in the public sector (i.e., in facilities primarily supported by governmental funds; local, state, or federal).

It is now possible to summarize:

Colorado has 700 to 850 mental health professionals, 10-30% above the national average. 573 are in the public sector, in clinics and tax-supported institutions. 55 are in community clinics, probable starting point for comprehensive mental health centers.

Extrapolations from national projections suggest that by 1970, Colorado should have a total of 870 mental health professionals if it is to keep pace with national averages. If it were to serve all its populace with comprehensive mental health centers, it would require some 660 professionals for this purpose alone -- 600 more than are presently in the clinics.

If it were just to bring its community outpatient clinics up to minimum accepted strength, it would need 121 additional professionals. Agencies queried during the planning project estimated a need in the next three years for 261 additional core professionals and 259 nurses.

Combining all estimates, there is an "annual need"[7] for:

13 — 25 new psychiatrists per year.

19 — 26 new Ph.D. psychologists per year.

8 — 12 new M.A. psychologists per year.

25 — 40 new MSW social workers per year (for mental health settings only)

60 — 85 new psychiatric nurses per year.

TOTALS: 125 —188

II. Data Collected: Current Production of Manpower:

Questionnaires were sent to as many persons graduating in the various mental health fields as could be reached in the months of June-September, 1964. These new graduates were queried as to whether they intended to work in a mental health setting, what state they intended to work in first, and whether they were eventually going to work in Colorado. 247 replies were tabulated: These included:

12 psychiatrists
12 psychologists (all C.U. grads, all Ph.D. candidates)
54 social workers receiving MSW
11 graduate nurses receiving MS
55 nurses receiving BS.
103 nurses receiving three year certificate.

TOTAL: 247

Of these, the following planned to work in a mental health setting:

Yes		Uncertain		No	
11	psychiatrists			1	
6	psychologists	1	uncertain	5	
15	social workers	3	uncertain	36	
7	MS nurses	2	uncertain	2	
4	BS nurses	1	uncertain	50	
8	nurses with three year certificate	9	uncertain	86	
TOTAL: 51		TOTAL UNCERTAIN: 16		TOTAL NO: 180	

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[7] This need takes no account of deaths and the need to replace those who leave the field for other reasons.

Thus, it may be said that identifiable "production" in 1964 was 51 mental health professionals. Denver University now has a doctoral program in psychology which should augment this total. And Colorado State University had 4 candidates graduating with degrees in counseling psychology in 1965.

These figures should be compared with estimated annual needs on page 6. It appears that total production is about 40% of minimal need. The next problem is to determine how many of these new graduates remain in Colorado immediately after graduation.

	Remain in Colorado	Not Remaining in Colorado
Psychiatrists	5	7
Psychologists	2	10
Social workers	31	23
MS nurses	6	5
BS nurses	35	20
Three-year nurses	76	27
	155	92

When these figures are applied to those entering mental health fields in Colorado the picture is as follows:

Psychiatrists	5
Psychologists	1
Social workers	9
MS nurses	4
BS nurses	3
3 Year nurses	6
TOTAL:	28 Mental Health Pro's Remaining in Colorado

Some 45% of those who were not going to practice in Colorado at once said they planned to come back to Colorado for work someday. Thus, an annual production rate of 28 mental health workers for Colorado would be augmented by some 10 people a year coming back to the state after having once been trained in it. Using these figures with all the caution they require, it could be optimistically said that Colorado gets about 30% of the mental health professionals it needs from its own training efforts (the logic: 38 is 30% of the minimum need of 125 on p. 175).

Additional data suggests that about 50% of the professionals in Colorado's mental health services were trained in this state. The 353

agencies filling out the basic mental health planning questionnaire revealed 574 personnel trained in Colorado, 587 elsewhere (see Table V). Of 269 individual mental health practitioners tabulated in Table VI, 129 were trained in Colorado, 140 elsewhere.

To follow further this line of thought, Colorado now seems to train 30% of its needed mental health practitioners through its own efforts. It presumably attracts another 30% trained elsewhere. Where shall it obtain the additional 40% to meet its minimum needs?

There would appear to be three avenues:

1) Increase its own training facilities.

2) Attract more outsiders through improved program opportunities and more vigorous recruiting.

3) Utilize lesser trained professionals.

Table VII summarizes some incomplete data on anticipated training policies of various institutions in Colorado. Modest increases are foreseen in the fields of social work and psychology by 1970. Psychiatric nursing appears to be planning major increases, eight times as many master's degrees in both psychiatric and public health nursing.

Fort Logan and Colorado State Hospital have shown that modern programs attract outside personnel from other states. On the other hand, the push for new comprehensive centers through the country will probably increase recruiting competition fiercely. Already, Illinois and California, for instance, have drawn off some of Colorado's most gifted professionals.

The third alternative is one much discussed these days. Utilizing lesser trained professionals can mean a return to the standards of the old-fashioned bughouse -- with ill-educated "attendants" substituting for absent professionals. Or, with improved use of in-service, undergraduate programs in both junior colleges and four year schools, skilled deployment of volunteers, and perhaps the use of the so-called "indigenous non-professional" (especially among social groups difficult for middle-class professionals to communicate effectively with), it could presumably fill a manpower gap that until now has seemed insuperable.

These are some of the issues requiring further exploration by this task force.

APPENDIX: DATA ON MENTAL HEALTH MANPOWER

TABLE I:

Manpower Deployed In Community Mental Health Clinics:

Hours by Discipline, Fiscal 1963-64; 1970 Needs.

Region	Outpatient hours per year			Total Staff Hours	Composite Persons	Min. Need, Staff Persons	% of Need Met
	Psychiat.	Psychol.	Social Work				
1	195	744	115	1,054	.5	11.6	4.5%
2	228	2,160	2,160	4,548	2.3	3.7	61.7
3	612	1,820	3,840	6,272	3.1	6.	52.5
4	1,136	717	1,072	2,925	1.5	7.	20.8
5	532	286	1,924	2,742	1.4	4.4	31.2
6	187	333	191	711	.4	3.5	10.2
7	470	1,890	2,493	4,853	2.4	5.8	41.9
8	2,184	4,656	2,744	9,584	4.8	17.	28.1
9	322	686	662	1,670	.8	5.1	16.4
10	795	1,580	4,353	6,728	3.4	13.7	24.6
Denver	9,123	3,882	14,359	27, 364	13.7	46.4	29.5
Adams	878	2,206	6,154	9,238	4.6	13.7	33.7
Arapahoe	2,576	4,152	5,139	11,867	5.9	13.0	45.6
Jefferson	2,016	3,473	5,373	10,862	5.4	16.3	33.3
Boulder	1,042	4,895	4,477	10,414	5.2	8.1	64.4
All Region 11	15,635	18,608	35,502	69,745	34.9	97.5	35.8
All Regions 1-10	6,661	14,872	18,554	41,087	20.5	77.8	25.
TOTALS:	22,296	33,480	54,056	110,832	55.4	175.3	31. %

TABLE II: Staffing Patterns And Anticipated Needs: 353 Mental Health And Allied Agencies -- 1964

	Mental Health Settings	Non-Mental Health Setting	Additions Needed, Next 3 Years: Mental Health	Additions Needed, Next 3 Years: Non-Mental Health
Psychiatrists	82	4	57	17
Psychologists, Ph.D.	58	13	57	22
Psychologist, M.A.	23	12	25	10
Social Workers, M.S.W.	147	149	122	99
Nurses, RN	473	255*	259	65*
Social Work - 1 year Training	-	103*	-	N.D.
Social Work - No Training	-	314*	-	N.D.
TOTALS	783	850*	520	213*

* These figures are probably underestimates since efforts to include non-mental health agencies -- except for public welare and public health -- were not systematically attempted.

TABLE III: Manpower Deployed in Public Mental Hospitals,

December 31, 1964

Name of Hospital	Psychiatry hrs./yr.	pers.	Psychology hrs./yr.	pers.	Social Work hrs./yr.	pers.	Total, 3 disci-plines	Nursing hr./yr.	pers.
Colo. State Hospital*	40,600	20.3	26,000	13	58,400	29.2	62.5	199,000	99.5
Ft. Logan M.H. Center	30,600	15.3	22,000	11	59,000	29.5	55.8	165,000	82.5
Colo. Psych. Hospital**	52,500 (91,500)	26.3	28,000 (16,000)	14	42,000 (8,580)	21	61.3	114,600	57.3
TOTAL STATE	123,700	61.9	76,000	38	159,400	79.7	179.6	478,600	239.3
Denver V.A.**	18,250 (8,000)	9.2	10,000 (14,000)	5.	10,000 (2,808)	5.	19.2	15,000	7.5
Ft. Lyon V.A.**	18,000	9.0	6,000 (3,500)	3.	16,000	8.	20.0	66,000	33.
TOTAL V.A.	36,250	18.2	16,000	8.	26,000	13.	39.2	81,000	40.5
Denver General	9,200	4.6	4,000	2.	14,300	7.2	13.8	12,000	6.
TOTAL, PUBLIC HOSPITAL	169,150	84.6	96,000	48.	199,700	100.	232.6	571,600	285.8

* Hours include trainees.

** Parenthesis depict trainee hours -- not otherwise included in tables.

Source: Inventory Data Supplied For State Construction Plan, for Comprehensive Community Mental Health Centers, August 1965.

TABLE IV: (A) Manpower Deployed in Private Psychiatric Hospitals and General Hospitals with Psychiatric Beds - December 31, 1964

(B) Totals, Tables III and IV.

Name of Hospital	Psychiatry hrs./yr.	pers.	Psychology hrs./yr.	pers.	Social Work hr./yr.	pers.	Total 3 Discip.	Nursing hrs./yr.	pers.
(A) Brady	15,000	7.5	2,000	1	One Vacancy		8.5	24,000	12
Bethesda	5,300	2.7	-		-		2.7	33,400	16.7
Mt. Airy	2,400	1.2	-		-		1.2	60,000	30.
Weld	500	.3	-		-		.3	12,000	6.
St. Francis*	1,500	.8	-		-		.8	23,000	11.5
Mary Corwin*	2,250	1.2	2,000	1	-		2.2	11,000	5.5
Porter*	6,000	3.0	1,000	.5	-		3.5	21,250	10.6
St. Joseph*	13,500	6.8	-		-		6.8	15,600	7.8
St. Luke	Unk.	Unk.	-		-		Unk.	Unk.	Unk.
Boulder Memorial	Unk.	Unk.	-		-		Unk.	8,000	4
TOTAL	46,450	23.5	5,000	2.5	None		26.	208,250	104.1
(B) TOTAL PUBLIC (TABLE III)	169,150	84.6	96,000	48.	199,700	100	232.6	571,600	285.8
STATE TOTAL	215,600	108.1	101,000	50.5	199,700	100	258.6	779,850	390.

* Note: Hours include estimates for part-time staff: psychiatrists estimated at 15 hours per week each, psychologists at 10 hours per week each.

TABLE V: State in Which Mental Health Staff in 353 Colorado Agencies Obtained Training (1964 Questionnaire).

Agencies	Colorado	Elsewhere
Psychiatrists	97	82
Psychologists	88	84
Social Workers	271	205
Nurses	118	216
TOTAL	574	587

TABLE VI: States in Which 900 Practitioners Were Trained

(Individual Persons queried in Individual Questionnaire, 1964)

	Colorado	California	Other States	Total Out of State	Sample Total
M.D.'s	152	19	297	316	468
Psychiatrists	28	1	28	29	57
Psychologists	31	1	40	41	72
Social Workers	60	4	64	68	128
Nurses	10	-	2	2	12
Lawyers	21	-	6	6	27
Ministers	28	9	99	108	136
TOTALS	330	34	536	570	900

TABLE VII: 1964 Graduates and 1970 Estimates: Selected Training Institutions, 1965

	Finished Last Year	To Finish, 1970	% Recruited from Colorado
Nursing -			
St. Joseph 3 Year RN	30	45 - 50	80%
C.U. - Nursing			
M.S., psychiatric	11	80	10
M.S., pub. health	8	65	20
M.S., administration	10	25	20
St. Luke's	36	45	55
Penrose	19	20	80
TOTAL	114	285	
Social Work - D.U.			
Casework	60	70	20%
Groupwork	3	10	20
C. O.	1	8	20
TOTAL	64	88	20
Psychology -			
C. U.	6	11	30%
C.S.U. Counseling	4	10	45
D.U. Child Study Center	0	5	50
TOTAL	10	26	

ROSTER: MANPOWER TASK FORCE

Dr. Herbert S. Gaskill, Chairman
Professor & Chairman
Department of Psychiatry
University of Colorado
Medical School

Dr. Edward G. Billings
1820 High Street
Denver, Colorado

Dr. Gaston E. Blom
Chief, Children's Division
Associate Professor
Department of Psychiatry
University of Colorado
Medical School

Mrs. Lee Ford
Public Health, Mental Health
Nursing
School of Nursing
University of Colorado
Boulder, Colorado

Dr. Robert Hewitt
Succeeded by:
Mrs. Howard Higman
Western Interstate Commission
for Higher Education
University Campus
Boulder, Colorado

Dr. Kenneth L. Little
Department of Psychology
University of Denver

Dr. Sherman Nelson
Fort Logan Mental Health Center
Fort Logan, Colorado

Dr. E. Papathomopaulos
Succeeded by:
Mr. Ray Krehoff
Personnel Department
Colorado State Hospital
Pueblo, Colorado

Dr. Victor Raimy
Senior Clinical Psychologist
Department of Psychology
University of Colorado
Boulder, Colorado

Dr. Emil Sunley, Dean
Director, School of Social
Work
University of Denver

Mrs. Opal White
Psychiatric Nursing
School of Nursing
University of Colorado Medical
Center

Staff:

Dr. Hans M. Schapire
Mr. Stanley W. Boucher
Mr. Marvin Meyers (Division
of Mental Retardation)

FUTURE LEGISLATION

A nine member task force on legislation, chaired by Judge Marvin Foote of the 18th Judicial District, worked from April, 1964 through January, 1965. After reviewing a number of possible areas for legislation, the group decided to concentrate upon re-writing the Short-Term Commitment Law (sometimes called the "Hold-And-Treat law). This proved an arduous and exacting task. But the revised law passed the legislature in February, 1965. In addition, a number of minor changes were made such as making all commitments to state hospitals directly to the Department of Institutions instead of to individual hospitals and giving the department power to control admissions to its new treatment centers for children.

The task force recognized that many of the recommendations of the State Mental Health Planning Committee would eventually require legislation. It was deemed wiser not to anticipate these recommendations and to wait until they had been sufficiently clarified before working to formulate them into legislative recommendations. It was also recognized that a committee on legislation, either on a continuous basis or in ad hoc form almost every year, will continue to be a vital aid to the State Department of Institutions.

The most obvious areas for a legislative committee to tackle next would appear to be:

I. Legislation to set up machinery whereby counties or groups of counties would create mental health boards. Such boards would include professional and lay membership. Their duties would be to examine the mental health needs of their region, to develop methods for better meeting those needs, and to receive -- if they deemed it wise -- state and local funds for financing community mental health services. If possible, federal funds for staffing, etc., would also go to these mental health boards. The need for regional mental health boards is one of the strongest recommendations of the State Mental Health Planning Committee.

II. State matching funds should be developed for the purchase of in-patient hospital care, partial hospitalization, and emergency services so as to augment present state aid for outpatient and consultation services. It is recognized that Federal staffing funds may temporarily assist a number of communities to get comprehensive mental health centers underway without additional state help. But such aid is to be on a declining basis, scheduled to phase out within five years. Even if it continued, the state should assume part of the burden so as to continue its progressive role in meeting the mental health needs of its citizens. This role, since 1957, has included aid to community mental health services.

III. A number of task force recommendations in the areas of research, alcoholism and addiction, case registers, etc., will require legislation in order to become realities.

IV. The basic "long-term" commitment law could stand extensive revision -- possibly even merging with the short-term act. The task force under Judge Foote considered attempting this but decided time pressures would not allow such an extensive task before the 1965 legislature. But the task force felt such revision should be attempted in the future.

V. There remains still many vexing problems concerning the so-called "criminally insane", the possibility of a second treatment and diagnostic center for this group to be located in Denver, and similar problems regarding the mental health status of inmates in non-mental health settings such as the Children's Home, the institutions for delinquent boys and girls, etc.

TASK FORCE ON LEGISLATION: MEMBERS

Judge Marvin Foote, Chairman
Arapahoe County Courthouse
Littleton, Colorado

Mr. Eugene A. Frantz
Attorney at Law
7180 West 14th Avenue
Lakewood, Colorado

Mr. Victor Grandy
Attorney at Law
Majestic Building
Denver, Colorado

Mr. William McGehee
Attorney at Law
Security Building
Denver, Colorado

Mr. Al Menard, Jr.
Acting Dean
University of Colorado
School of Law
Boulder, Colorado

Judge J. Robert Miller
Larimer County Court
Fort Collins, Colorado

Respresentative Ted Rubin
Attorney at Law
Western Federal Savings
Building
718 - 17th Street
Denver, Colorado

Hans M. Schapire, M. D.
Director
Mental Health Planning Project
Department of Institutions
328 State Services Building
Denver, Colorado

Mr. Stanley W. Boucher, ACSW
Assistant Director
Mental Health Planning Project
Department of Institutions
328 State Services Building
Denver, Colorado