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0042 Juvenile Mental Health: Programs and Needs

Colorado Legislative Council

Report to the Colorado General Assembly:

JUVENILE MENTAL HEALTH

Programs and Needs

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 42

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LEGISLATIVE COUNCIL

OF THE

COLORADO GENERAL ASSEMBLY

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The Legislative Council, which is composed of five Senators, six Representatives, and the presiding officers of the two houses, serves as a continuing research agency for the legislature through the maintenance of a trained staff. Between sessions, research activities are concentrated on the study of relatively broad problems formally proposed by legislators, and the publication and distribution of factual reports to aid in their solution.

During the sessions, the emphasis is on supplying legislators, on individual request, with personal memoranda, providing them with information needed to handle their own legislative problems. Reports and memoranda both give pertinent data in the form of facts, figures, arguments, and alternatives.

LEGISLATIVE COUNCIL

REPORT TO THE

COLORADO GENERAL ASSEMBLY

JUVENILE MENTAL HEALTH PROGRAMS AND NEEDS

Research Publication No. 42

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 343, STATE CAPITOL
DENVER 2, COLORADO
KEystone 4-1171 — Extension 287

November 18, 1960

To Members of the Forty-third Colorado General Assembly:

As directed by the terms of House Joint Resolution No. 8 (1959), the Legislative Council is submitting herewith its report on Children's Laws. This report traces program developments and needs with respect to emotionally disturbed juveniles. No specific recommendations were made because the committee appointed by the Legislative Council to make this study was of the opinion that implementation of juvenile mental health services should be considered within the context of an over-all state mental health program. Such program had not been completely developed nor had the Department of Institutions become activated during the period in which the study was made.

This report was submitted to the Legislative Council on November 17, 1960, at which time the report was adopted by the Legislative Council for transmission to the General Assembly.

Respectfully submitted,

Charles Conklin

Charles Conklin
Chairman

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 343, STATE CAPITOL
DENVER 2, COLORADO
KEYSTONE 4-1171 — EXTENSION 287

LETTER OF TRANSMITTAL

November 18, 1960

The Honorable Charles Conklin, Chairman
Colorado Legislative Council
State Capitol
Denver 2, Colorado

Dear Mr. Chairman:

Transmitted herewith is the report of the Legislative Council Committee on Children's Laws, appointed pursuant to House Joint Resolution No. 8 (1959). This report covers the committee's study of programs and needs for emotionally disturbed juveniles.

Respectfully submitted,

/s/ Representative Elizabeth E. Pellet
Chairman
Committee on Children's Laws

FOREWORD

This study was made under the provisions of House Joint Resolution No. 8 passed at the first session of the Forty-second General Assembly. This resolution directed the Colorado Legislative Council to appoint a committee to continue the study of children's laws and child welfare in Colorado. The passage of this resolution marked the continuation of the Children's Laws study for the fourth successive two-year period. The Children's Laws study was authorized initially in 1953 and was one of the Colorado Legislative Council's first research projects.

The Legislative Council committee appointed to continue this study included: Representative Elizabeth Pellet, Rico, Chairman; Senator Rena Mary Taylor, Palisade, Vice-Chairman; Senator George Brown, Denver; Representative Joseph Calabrese, Denver; Representative Norman Enfield, Colorado Springs; and Representative Madge Gaylord, Pueblo. Harry O. Lawson, Legislative Council senior research analyst, had the primary responsibility for the staff work on this study.

During 1959, the committee concentrated its efforts on program needs for mentally retarded trainable children. As a result of the committee's study and recommendations, House Bill 36 was passed at the second session of the Forty-second General Assembly in 1960. This legislation provided for a pilot program for trainable children, to be established in a limited number of school districts, with state aid on a 50-50 matching basis.

In 1960, the committee again turned its attention to emotionally disturbed juveniles, a subject studied to some extent during the 1957-1958 biennium and included in the committee's report to the Forty-second General Assembly. While juvenile mental health needs are outlined in this current report, the committee did not make any specific recommendations for legislative action. As the planning and development of the state's over-all mental health program is still in the early stages, the committee considered it premature to make specific recommendations at this time. In the committee's opinion, the provision and expansion of mental health services for juveniles can best be accomplished within the context of the long-range plan for the over-all state mental health program, and specific proposals for meeting juvenile mental health needs should be examined and evaluated with reference to over-all mental health needs and priorities.

Besides outlining current juvenile mental health needs, this report traces the administrative, institutional, and legislative developments during the past biennium which have some bearing on programs and services for emotionally disturbed juveniles.

Lyle C. Kyle
Director

November 17, 1960

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PREVIOUS STUDY AND RECOMMENDATIONS

During the 1957-1958 biennium, the Children's Laws Committee considered needs and programs for emotionally disturbed juveniles in conjunction with its major study of juvenile probation and parole. The committee's study, with findings and recommendations pertaining to emotionally disturbed juveniles, was covered in the committee's report to the Forty-second General Assembly.[1]

The following points were included in the committee's study of the emotionally disturbed juveniles:

1) examination of local needs as expressed at the regional meetings held by the committee throughout the state;

2) survey of existing programs and the agencies and institutions involved;[2]

3) determination of needs based on the regional meetings and the survey of existing programs, the experience of the Children's Diagnostic Center, and the Denver Metropolitan Area Study made by the Denver Welfare Council; and

4) meetings with officials of agencies and institutions concerned and with others to develop a program for emotionally disturbed juveniles.

1957-1958 Recommendations

As a result of its work on this problem in 1957-1958, the committee made the following recommendations:

1) The operation of the Children's Diagnostic Center should be continued at the current level until the details of an over-all program are worked out.

2) Steps should be taken to develop a centrally-coordinated institutional program.

3) The General Assembly should consider providing additional funds for the development of community and regional mental health clinics.

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1. Juveniles in Trouble, Probation-Parole-Mental Health, Colorado Legislative Council, Research Publication #25, December, 1958, Part III, pp. 31-47.
2. Agencies and institutions involved included: Department of Institutions; Department of Welfare; Boys' Industrial School; Girls' Industrial School; Children's Home, community clinics; Colorado University Medical Center; Children's Diagnostic Center; Mental Health and Special Education Division, Department of Education; and Department of Public Health.

4) A day care center should be established on a pilot basis as the first step in a residential treatment program.

5) A study should be made of the State Children's Home and consideration given to changing the functions of the home, so that a complex of diagnostic and treatment facilities might be established.

6) Additional professional staff should be provided at the State Industrial School for Boys (Golden) and the State Training School for Girls (Morrison), as well as the development of treatment-oriented programs.

Implementation of Recommendations

All of these recommendations were carried out, at least to some extent, by the General Assembly and the executive branch, even though there was no committee-sponsored legislation, as such, covering any of these points. The Children's Diagnostic Center was continued at the same operational level and with the same appropriation. House Bill 406, passed in 1959, reorganized the Department of Institutions and provided for interagency cooperation. In addition, the Governor appointed an ad hoc committee on mental health to study needs and programs with respect to both youth and adults.

Additional funds have been provided by the General Assembly for assistance to community mental health clinics. The University of Colorado Medical Center has included a 15-bed day care treatment center in its long-range building program, and it is expected that the center will be in operation some time during the 1961-1962 biennium.

In response to a request by the Children's Laws Committee and others, the Governor engaged the Child Welfare League of America to make a study of the Colorado Children's Home, including recommendations as to possible future programs at that institution. Following this study, the General Assembly (in 1959) passed House Bill 504 limiting intake at the home of youngsters under seven years of age. Professional staff has been added at both training schools, including part-time psychiatric consultants.

DEVELOPMENTS DURING THE 1959-1960 BIENNIUM

During the past two years, progress has been made toward the development of an over-all mental health program for Colorado. Many of the advances made have had an effect (both direct and indirect) on improving mental health services for juveniles. The criticism has been made that recent developments in the organization and extension of mental health services, particularly with respect to juvenile needs, have been too slow and limited. There is some justification for this criticism, but there are several reasons why the development of a comprehensive mental health program should be approached with caution and deliberation: 1) the complexity of services required; 2) the expense of providing these services; 3) the difficulty in securing professional personnel, especially psychiatrists; and 4) the need for efficient administrative organization and adequate long-range planning.

Centralized Program Control

Department of Institutions

House Bill 406, 1959, which reorganized the Department of Institutions, provided for a qualified director by authorizing the Governor to pay a salary for the position equal to the maximum paid to any civil service certified superintendent of any institution under the authority of the department. The Governor was also authorized to appoint an interagency council at his pleasure, selected from those state agencies most closely related to the institutional program. In addition, the Governor was given the authority to appoint advisory boards to consult with the director or the chief officer of any institution within the department. A further step toward centralized control was made in the act through the elimination of the two remaining institutional boards of control (girls' school and children's home).

Although the provisions of the act became effective July 1, 1959, a director of institutions has not yet been appointed. The delay in the appointment of an institutional director stems from efforts to fill the position with a well-qualified psychiatrist with considerable administrative experience and knowledge of public mental health institutions, programs, and services. The position apparently had been held open for Dr. Robert A. Felix, head of the National Institute of Health in Washington, and a Colorado native and former resident. The delay was caused by Congressional consideration of legislation modifying the retirement regulations pertaining to personnel in the employ of the United States Surgeon-General. Even though such legislation was passed, Dr. Felix refused the present position. Other applicants are being considered, as are different approaches to filling the position, such as combining the posts of director of institutions and superintendent of the state hospital at Pueblo. The position of director of psychiatric services within the Department of Institutions also has not as yet been filled.

The Governor has exercised his authority to appoint an institutional interagency council. This council was appointed in the fall of 1959 and consists of the following officials: William Welsh, Civil Service Commission; Guy Justis, Director, Department of Welfare; Dr. Roy Cleere, Director, Department of Health; John Swenson, Department of Education; William Williams, Director, Planning Division; Bernard Teets, Director, Department of Employment; Warren Thompson, Director, Department of Rehabilitation; and Con Shea, Budget Director. In the absence of a director of institutions, the Governor has served as chairman of the interagency council. The council has held several meetings, concerned primarily with construction and programs at the state hospital in Pueblo.

Department of Rehabilitation

The Department of Rehabilitation was created by House Bill 467 passed in 1959. Consolidated within this department are the duties and functions formerly assigned to the Vocational Rehabilitation Division of the State Board of Vocational Education, as well as duties and functions pertaining to rehabilitation of the blind, formerly assigned to the Division of the Blind and to the Department of Welfare. This agency is of importance in mental health programs for juveniles because of the sections of the act which authorize the department to provide rehabilitative services to persons with mental as well as physical handicaps, and to cooperate with other departments and agencies in providing such services. The act provides further that upon designation by the Governor, the department may undertake programs and services in connection with the federal government, with the utilization of federal funds. The Department of Rehabilitation has provided rehabilitation counselors at both Golden and Morrison and some psychiatric evaluation in conjunction with the rehabilitation program.

Governor's Ad Hoc Committees on Mental Health

The Governor's first ad hoc committee was appointed in January, 1959 under the chairmanship of Dr. James Galvin, Director of Colorado Psychopathic Hospital. The committee was concerned primarily with the development of an over-all mental health program, from community services to residential treatment for both children and adults. In its report, this committee recommended that the Children's Diagnostic Center be moved to Fort Logan and that a 20-25 bed residential treatment center be established at Fort Logan, with both these units to be separated from the other facilities to be constructed there. The report also stressed the need for expanded community clinical facilities for both adults and juveniles.

The second ad hoc committee was appointed in January, 1960. This committee was chaired by Dr. Franklin G. Ebaugh. Dr. Herbert S. Gaskill, Director of Psychiatric Services, University of Colorado Medical Center, served as vice-chairman. The second ad hoc committee also concerned itself with the planning and development of a comprehensive mental health program for Colorado.

This committee's report was issued in May, 1960, and its recommendations were reported in an article in the May issue of the Rocky Mountain Medical Journal, written by Drs. Ebaugh and Gaskill:[3]

1. Separation of mental health administration from other state departments by the creation of a directorship of psychiatric services, through whom integration and communication can be facilitated. The manner in which individual community facilities are organized is considered to be of minor importance, provided a general director is invested with authority to establish over-all policy, and to offer consultation on organizational problems.

2. Development of transitional services to facilitate optimal movement and care of patients en route to and from the hospitals.

3. Decentralization of the existing State Hospital facilities through remodeling and reorganizing the Pueblo institution, creating an additional State Hospital at Fort Logan, developing integrated out-patient services and clinics in connection with both hospitals, and generally removing legal restrictions which hamper the flow of communication and voluntary admissions. Provisions for maximum interaction among treatment agencies must necessarily be written into the basic administrative policies of the state Mental Health Program.

4. Specialization of facilities, with emphasis upon providing optimal treatment programs for various types of mental health problems, notably those concerned with mental deficiency, senility, criminal insanity, definitive psychiatric categories, and emotionally disturbed patients who do not require hospitalization.

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3. Rocky Mountain Medical Journal, "Comprehensive Psychiatric Services for the State of Colorado," Dr. Franklin G. Ebaugh and Dr. Herbert S. Gaskill, May, 1960.

5. Provision of an adequate quantity and quality of nursing homes throughout the state, and the channeling of senile patients to those homes, thus relieving the State Hospitals of custodial functions.

6. Creation of adequate residential and day-care treatment centers for disturbed children.

7. Expansion of psychiatric facilities (for both hospitals and clinics) for the present and the future. The manpower problem can also be reduced by further encouraging the general practitioner to a leadership role in the community mental health development.

8. Appropriate modification of Legislative Acts and restrictions, for purpose of facilitating development of a flexible, comprehensive mental health program in the State of Colorado.

While the second ad hoc committee recommended the creation of adequate residential treatment centers for emotionally disturbed juveniles, no indication was made as to where these facilities should be located. Dr. Ebaugh and Dr. Gaskill told the Children's Laws Committee that they were not sure that Fort Logan (as recommended by the first ad hoc committee) would be the best place for such a facility, even though the building plans for Fort Logan include a residential treatment unit for juveniles.[4] They agreed that the State Children's Home might be a better location, but further study is needed.[5]

Governor's Advisory Committee on Mental Health

On May 12, 1960, the Governor replaced the second ad hoc committee with a permanent Advisory Committee on Mental Health. This committee is also chaired by Dr. Ebaugh and is composed of some 15 members, including psychiatrists, physicians and surgeons, representatives of bench and bar, and medical and hospital administrators. Several consultants, experienced in the various phases and disciplines involved in mental health services, have also been appointed.

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4. Minutes of Legislative Council Committee on Children's Laws, Meeting of May 26, 1960.
5. Ibid.

This committee has held several meetings, considering overall administrative organization; recruitment of the director of institutions, director of psychiatric services, and other professional personnel; residential treatment; community mental health clinics; and commitment and transfer laws. Three sub-committees were appointed: administrative, psychiatric, and legal.

Administrative Organization

All of the agencies and committees studying mental health needs appear to be in general agreement that there should be centralized control and responsibility for all parts of the program insofar as practical. This was the intent of House Bill 406 (1959) which placed all institutions, as well as the adult and juvenile parole divisions, under the Department of Institutions, with provision for divisions within the department for corrections, psychiatric services, and parole. (This legislation did not transfer the administration of community mental health clinics from the Department of Health, although such transfer has been recommended by many of those supporting central coordination.) Under the administrative arrangement provided in House Bill 406, the mental health program would be under the director of psychiatric services, who would also coordinate mental health services within the other divisions.

Even though the administrative organization contemplated in House Bill 406 has not yet been implemented,[6] so that its adequacy could be determined from actual experience, a recommendation has been made for separate departments of mental health and corrections.[7] Dr. Paul Hoch, Commissioner of Mental Hygiene, State of New York, and special consultant on mental health to the Governor and the advisory committee, has strongly recommended this administrative realignment. Included in the Department of Mental Health would be the state hospital at Pueblo, the new facility at Fort Logan, the institutions for the mentally retarded, the boys' industrial school, and the girls' training school. At the time of this report, the Children's Laws Committee had no information as to whether this recommendation had been accepted by the advisory mental health committee and/or the Governor.

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6. Primarily because the director of institutions and director of psychiatric services have not been appointed.
7. The Establishment of a Separate Department of Mental Health and Executive Director, Report on the Mental Health Program of the State of Colorado, Paul H. Hoch, M.D., February, 1960.

Community Mental Health Clinics

There are now 12 community mental health clinics located as follows:

County or Area	Location
Adams	Brighton
Arapahoe	Englewood
Boulder	Boulder
Denver	Denver General[8]
El Paso	Colorado Springs
Jefferson	Golden
Larimer	Fort Collins
Mesa	Grand Junction
Pueblo	Pueblo
Weld	Greeley
NE Colorado (Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma)	Sterling
San Juan Basin (Archuleta, Dolores, La Plata, Montezuma, and San Juan)	Durango[9]

In addition, there is a clinic in La Junta (Otero) staffed on a part-time basis by the State Department of Health.

Provision of State Funds

During the fiscal year of 1957-1958, state funds were available for the first time to assist in the financing of community mental health clinical services. At that time, nine clinics qualified for financial assistance. These included all of these enumerated above, with the exception of Jefferson, Northeast Colorado, San Juan Basin, and Otero. Beginning with the 1959-1960 fiscal year, the Northeast Colorado clinic also began receiving state funds. The annual amount of state aid and per cent of increase is as follows:

Fiscal Year	State Aid	Per Cent of Annual Increase
1957-1958	$ 48,095	----
1958-1959	74,200	54.3
1959-1960	83,000	10.5
1960-1961	132,843	60.1

The state aid total for 1960-1961 of $132,843 represents 37 per cent of the estimated total clinic budget of $359,432. Following is the ratio of state aid to total clinic budgets by fiscal year:

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8. There is also an outpatient clinic operated by the Colorado Medical Center.
9. Scheduled to get underway in the late fall, 1960.

Fiscal Year	State Aid	Total Clinic Budgets	Per Cent of State Aid
1957-1958	$ 48,095	$ 120,140	40.0
1958-1959	74,200	150,668	49.2
1959-1960	83,000	186,348	44.5
1960-1961	132,843	359,432	37.0

It is interesting to note that local support for community clinics has increased at a greater rate during the four-year period than has state aid. State aid has increased 176.2 per cent, while local support has increased 199.2 per cent during the same period.

Six of the present 12 clinics are operating on a full-time basis--Arapahoe, Boulder, Denver, El Paso, Pueblo, and Weld. According to the Mental Health Division, State Department of Health, all of the part-time clinics (as well as the full-time clinics) have plans to increase services, but such plans are predicated on the availability of funds over and above the amount of state and local aid available for 1960-1961.

Requests for traveling clinics have been received during the past year by the Mental Health Division from three areas where no services are now provided--Glenwood Springs, Salida, and Trinidad. The Mental Health Division reports that it is difficult to meet these requests because of limited funds and personnel and the amount of travel time involved.

In order for a community mental health clinic or program to qualify for state financial support, it must meet certain standards established by the Mental Health Division. These standards include local community participation and support as well as a realistic appraisal of community need.

Administration and Expansion of the Community Mental Health Clinic Program

State assistance and administration of the community mental health clinic program continue to be responsibilities of the Mental Health Division, State Department of Health. Advocates of transferring this program to the Department of Institutions argue that each aspect of the total mental health program should be viewed as part of one continuous process: outpatient care and diagnosis on the local level, transfer to institutional care of those who need it, and after care and treatment on the community level for those patients released from institutional care. Further, it is pointed out that a total mental health program can be developed and operated adequately only if all parts of the program are integrated and considered in relation to each other.

On the other hand, the Division of Mental Health is a "going operation" with several years' experience in working with and assisting community clinics. It would be very difficult to justify transfer of this function at this time to the

Department of Institutions, when that department has no director and is not in operation. The uncertainty as to whether there will be a further change in administrative organization (separate Department of Mental Health), is another argument against transfer of the community clinic program at this time.

Expansion of the community clinic program is generally considered the cornerstone of the over-all mental health program development. Early diagnosis and outpatient therapy obviate the the necessity for residential treatment in a large number of cases. Diagnosis and therapy can be provided by community clinics much more cheaply and for many more patients than can residential care. The community clinics, if adequately staffed, are also able to provide outpatient therapy and after-care, not only for patients released from residential treatment, but also for adult and juvenile parolees who need such help.

By comparison with other states which are considered to have done the best job in developing a community clinic program,[10] state aid should be increased to 50 per cent from the present 37 per cent. Colorado has additional problems, however, caused by large sparsely-populated areas and the difficulty in finding professional personnel willing to settle in small communities away from educational and professional facilities, despite salary inducements.

Until the question is definitely answered as to which agency will have the responsibility for administering the community clinic program, it is unlikely that sufficient state funds will be provided to expand the community clinic program to the desired level. Nevertheless, the Mental Health Division, Department of Health, has gone ahead with the planning and development of an enlarged program.[11]

The program proposed by the Department of Health would be organized and financed as follows:[12]

II. ORGANIZATION

A. The contemplated program is predicated on sound principles of community mental health and influenced by the needs, the geography and economy, and the present and future distribution of qualified personnel in Colorado. In essence, it is proposed that all available energies be concentrated on the strengthening

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10. California, New York, New Jersey, and Minnesota.
11. A Program for Community Mental Health Services in Colorado, Colorado State Department of Health, August 4, 1960.
12. Ibid.

and expansion of mental health services now in existence. State Office staff will primarily focus on coordinating the program. Community clinics will become multi-purpose and extend services to a larger area. The over-all goal is to provide as effective a level of mental health service for the State within as minimal a time as is possible. Its realization will be a cooperative State-local responsibility. Each clinic will operate on a shared-cost State-Community basis. The State will supplement initial community monies, but avoid stifling local participation, and inhibiting maximum utilization of indigenous resources. The State will set basic minimal standards, but personnel will be selected locally.

B. The plan involves the dividing of the State into six primary regions of organization and services for mental health. The core for services will be a full-time Regional Mental Health Center with a full staff resident personnel. Subsidiary Clinics will be established to extend service from these Regional Centers.

The regions, and the counties they will serve, are as follows, with the Regional Centers identified by their location site:

1. Metropolitan Area - The population density is such that there will actually be five Regional Centers based on the expansion of clinics now in existence:

   a) Denver General Hospital to continue to serve the City-County of Denver.
   b) Adams County Clinic to continue to serve its initial area.
   c) Arapahoe County Clinic to also serve Douglas County.
   d) Jefferson County Clinic to also serve Gilpin, Clear Creek and Summit Counties.
   e) Boulder County Clinic to include temporarily Larimer County until it can further develop its mental health services.

2. Northeast Colorado - Weld, Logan, Sedgwick, Phillips, Yuma, Washington and Morgan Counties.

   a) Weld Clinic to become the Regional Center.
   b) Sterling Clinic to become a subsidiary clinic to the Regional Center.

3. Central Colorado - El Paso, Teller, Lake, Chaffee, Park, Fremont, Elbert, Lincoln, Kit Carson, and Cheyenne Counties.

   a) Colorado Springs Clinic to become a Regional Center.
   b) Subsidiary clinics could be established in Salida and Limon.

4. Southeast Colorado - Pueblo, Custer, Huerfano, Las Animas, Otero, Crowley, Bent, Kiowa, Prowers, and Baca Counties.

   a) Pueblo County Clinic to become the Regional Center.
   b) Otero County Clinic to become a subsidiary clinic.
   c) Additional subsidiary clinics could be established in Lamar and Trinidad.

5. Southwest Colorado - Dolores, La Plata, Archuleta, Montezuma, San Miguel, Hinsdale, Saguache, Mineral, Rio Grande, Conejos, Alamosa, San Juan and Costilla Counties.

   a) Durango Clinic, which the San Juan Basin Health Unit is now establishing, will become the Regional Center.
   b) Subsidiary clinic could be located in Alamosa.

6. Western Slope - Mesa, Montrose, Delta, Gunnison, Ouray, Pitkin, Garfield, Eagle, Rio Blanco, Moffatt [sic], Routt, Jackson, and Grand Counties.

a) Grand Junction Clinic to become the Regional Center.
b) Subsidiary clinics could be located in Montrose, Glenwood Springs, and Steamboat Springs.

C. State Office staff will provide leadership in the integration of the community mental health program, and provide technical assistance in the establishment of the Regional Center.

FINANCING

The portion of State funds devoted to the support of the Community Mental Health Program will be distributed through the State Department of Public Health according to a per capita formula. Local communities will be expected to contribute to the support of Mental Health Centers on a 50-50 basis. Because of the variation among Colorado communities in resources which could be used to support mental health, the State may elect to pay a larger proportion of the cost for a limited period.

1. An annual plan and budget will be submitted by each Community Mental Health Center. This will be reviewed and evaluated by the Director of the Mental Health Division and his staff, and its approval will be necessary for the continued allocation of funds according to the above principles.

2. The Psychiatrist-Director will prepare the annual plan and budget for the approval of the local Health Director who will forward it to the Mental Health Division. The clinic will be administered according to this plan as approved by the State.

3. Until such time as it is permissible under the law for the local Health Unit to accept fees for service, the Advisory Board should organize itself either as a whole or in part so that it can accept the fees and channel them through the local Health Unit for the support of the mental health clinic. Legislation will be introduced in 1961 to accomplish this.

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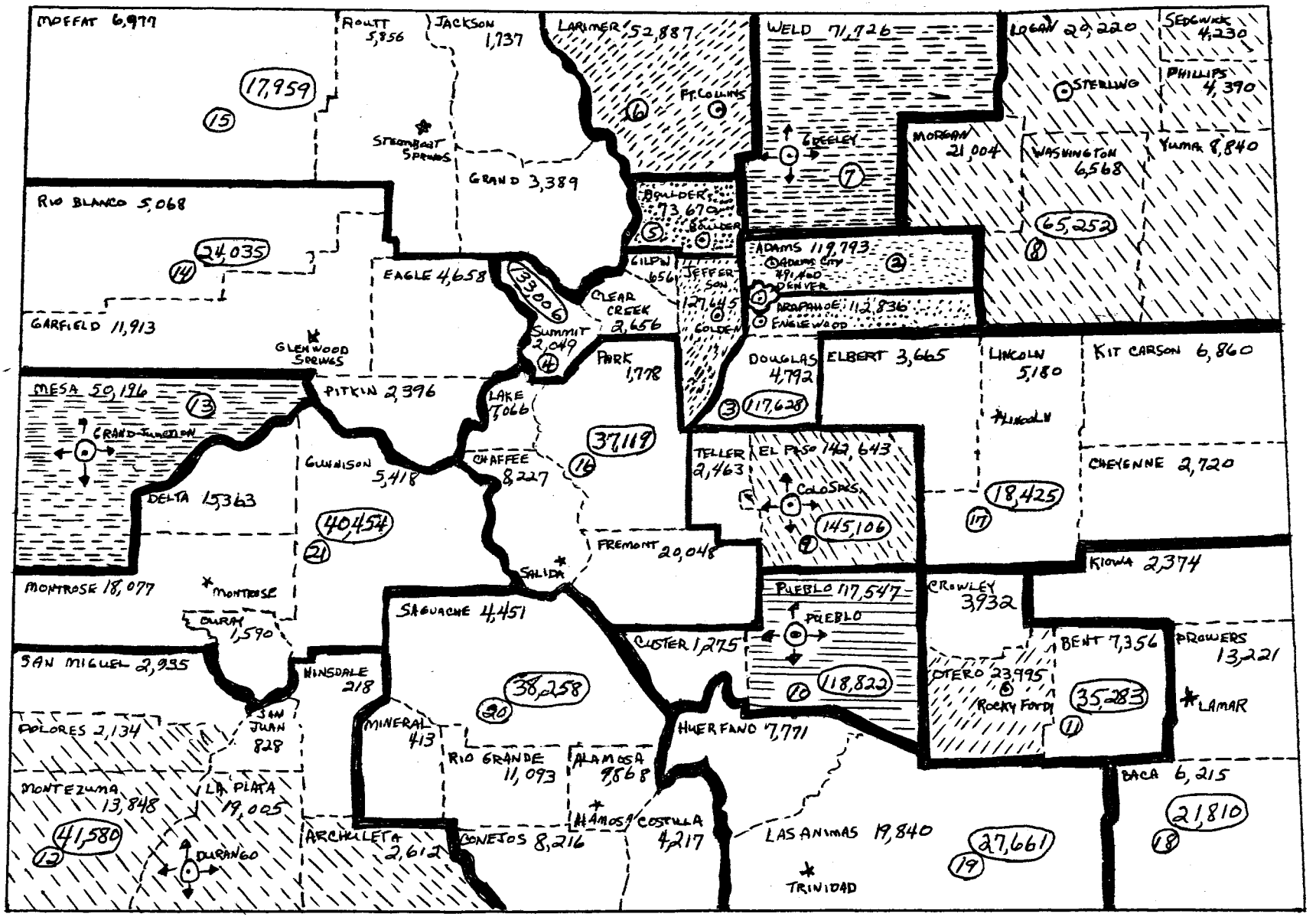
Proposed Community Mental Health Program for the State of Colorado With Twenty-One Community Mental Health Regional Districts



- DISTRICT BOUNDARIES WITH 1960 POPULATION CENSUS FIGURES
- CITIES WITH MENTAL HEALTH CLINICS
- PROPOSED KEY REGIONAL COMMUNITY MENTAL HEALTH CENTERS
- PROPOSED NEW DISTRICT LOCATIONS FOR COMMUNITY MENTAL HEALTH CLINICS (PART TIME OR FULL TIME)

* NOTE: SHADED AREAS — AREAS PRESENTLY SERVED BY LOCAL COMMUNITY MENTAL HEALTH SERVICES

Source: A Program for Community Mental Health Services in Colorado, Colorado State Department of Health, Aug. 4, 1960.

Children's Diagnostic Center

During the 12-month period from September 1, 1959 through August 31, 1960, there were 139 referrals to the Diagnostic Center. There has been a marked reduction in the number of referrals in comparison with previous years. From September 1957 through August 1959, the Diagnostic Center had between 20 and 25 youngsters referred each month or approximately 285 annually. The peak case load was reached in the last three months of 1958. At that time the Children's Laws Committee discussed with Colorado Medical Center officials the possibility of expanding the Diagnostic Center program. The Medical Center agreed to an expanded program, but wanted to limit such expansion to the extent that a maximum of 400 referrals would be handled on an annual basis. The committee was concerned with this limitation, and no action was taken with respect to expanding the Diagnostic Center, both for this reason and because the committee was of the opinion that such expansion should be considered in relation to an over-all mental health program for juveniles.

There are two major reasons for the reduction in referrals during the past 12 months:

1) The expansion of community mental health clinics has made it possible to handle a much larger number of diagnostic referrals in those areas where clinics are located.

2) At the suggestion of the Children's Laws Committee, the Diagnostic Center has imposed a more restrictive referral acceptance policy.

Effect of Community Mental Health Clinics

The community mental health clinic program affects referrals to the Diagnostic Center in two ways. The first, that of decreasing the number of referrals, has already been mentioned. While it appears true that, in the long run, community clinics will absorb a large proportion of the Diagnostic Center referrals, the creation of additional clinics has the short-run effect of increasing such referrals.

Usually, clinics are started on a part-time basis in areas where there have been no organized mental health services available. Community interest and need give impetus to setting up a clinic. The clinic then serves as a stimulus to public awareness of mental health problems. This increased awareness is accompanied by a greater demand for services than can be provided by a part-time clinic. As the diagnostic waiting list at the clinic grows, more youngsters from the area are referred to the Diagnostic Center. This situation continues until the clinic expands its operations, so that it can accommodate local demands for service more readily. When such expansion takes place, there is no longer as great a need for using the Diagnostic Center, with a resultant decrease in the number of youngsters so referred.

Effect of Former Liberal Admittance Policies

The act passed in 1955, which established the Diagnostic Center, provided for three types of referrals: 1) children before the court who may be committed to a state institution; 2) court referral as the result of the request by any medical commission appointed by the county judge to determine whether any youngster under 16 years of age is mentally retarded or incompetent; and 3) referral upon approval of the director of institutions by superintendents of state institutions to which children have been committed.[13]

Shortly after the center began operation, the admittance policy was liberalized. This was done with the approval of the director of institutions and was intended to encourage use of the center as well as to provide diagnostic services for as many children as possible. In effect, this liberalized policy circumvented the law, as it made it possible for youngsters who were not officially before the court to be referred to the Diagnostic Center.

Under this policy local welfare departments and schools could refer pre-delinquents and other youngsters who were suspected of having emotional problems, even though no act had been committed which would bring them officially before the court. The referral could be made by having the county judge make an informal request for diagnosis--usually by a letter to the Diagnostic Center. It was determined, upon analysis of referrals, that many children informally referred had been accepted by the Diagnostic Center upon receipt of a letter from the court clerk and that the judge had not participated in the action. Additional youngsters were referred informally by the judges themselves. This group included youngsters who were before the court as a result of a delinquent act alleged to have been committed by them, but whose cases were being handled informally by the judge.

While this liberalized policy made it possible for a number of youngsters to receive an early evaluation so that their problems might be handled by less intensive therapy than might be required later on, a number of problems resulted:

1) These referrals, if not illegal, were certainly extralegal. At the request of the Children's Laws Committee, a conference was held on this problem by the Council staff with Professor Homer Clark, University of Colorado Law School, and legal advisor to the Children's Laws Committee, and Gail Ouren, at that time a member of the Attorney General's staff and legal advisor to the

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13. 124-3-28 CRS 1953 as amended; Denver was excluded from referring children to the Diagnostic Center, because of the availability of local services which the rest of the state did not have at the time the act was passed (1955).

State Welfare Department. It was the consensus of opinion that the only legal referrals were those in which the county judge made a formal commitment to the Diagnostic Center. There is no provision in Colorado's juvenile statutes for the informal handling of delinquency cases. Therefore, the interpretation was made that no matter could be before the county judge as specified in the statute pertaining to Diagnostic Center referrals unless the case was docketed and formal action was to be taken. These unofficial, extra, or non-legal referrals raised questions as to liability and whether counties and/or parents could be legally held liable for payments for room and board to the State Children's Home, where many Diagnostic Center referrals are housed.

2) These referrals so increased the demand for diagnostic services that a waiting list was created, which included many legal or formal referrals.

The Children's Laws Committee discussed admittance practices with the director and assistant director of the Diagnostic Center in September, 1959. It was agreed that the precedent which had been set would make it difficult to reverse the referral policy as quickly as might be desired, but that the effort should be made to discourage informal referrals, especially those which were made without the county judges' knowledge.

As a result of this discussion, the Diagnostic Center staff held a number of meetings with county judges and other local officials. These meetings were used, not only as a means of discouraging informal referrals, but also to provide consultation for the local areas on juvenile mental health problems and to encourage better utilization of local resources.

Effect of Referral Rate Reduction

The reduction in the Diagnostic Center referral rate has had a number of desirable consequences. More time can be given to each evaluation--up to four weeks--so that a more satisfactory diagnosis may be made. The center is able to follow up on a greater number of cases to determine what has happened to these youngsters. Center personnel also have more time to consult with and assist local officials and professional people in other disciplines such as teaching or social work.

Regardless of the temporary effect upon Diagnostic Center referrals as a result of new mental health clinics, it seems unlikely that there will be a need in the near future for a state diagnostic facility with a capacity much in excess of 300 annual referrals.

Day Care Center

The operational plans and budget for the proposed day care treatment center have been developed by the Colorado Medical Center. This center, which the medical school hopes to have in operation during the 1961-1962 fiscal year, will accommodate up to 15 youngsters. Referrals will come from a number of sources, including: the Diagnostic Center, the various community clinics, the courts, schools, and county departments of welfare.

Those children accepted by the day care center, whose homes are beyond commuting distance, will be placed in foster homes. Included in the proposed annual budget of $110,500 for operating the center is $10,000 for reimbursement of foster homes for five children and $5,000 for a social worker for the foster home program. These foster home program funds will be allocated to and administered by the Child Welfare Division of the State Department of Welfare.

Following is the detailed plan developed by the Colorado Medical Center for the day care treatment program.[14]

> The Division of Child Psychiatry is proposing that plans be developed and funds budgeted for a "Day Care Treatment Center" for certain types of emotionally ill children.
>
> The purposes of establishing such a center are fivefold:
>
> 1) To assist in meeting specific, urgent service needs of both the Denver area and of the state.
>
> 2) To provide a valuable addition to our training program in child psychiatry.
>
> 3) To develop an important training and demonstration unit for other disciplines such as teachers in special education, social workers, psychiatric nurses, group workers, and others.
>
> 4) To encourage the development of similar programs in the state.
>
> 5) To develop research in appropriate areas of child psychiatry.

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14. As submitted to the Committee on Children's Laws.

This center would accept for care approximately fifteen boys and girls between the ages of six and twelve. There would be three indications for admission of a child to this program:

1) A child whose psychiatric illness keeps him from attending public school.

2) A child whose social and educational adjustments are marginal.

3) A child who requires the special therapeutic school experience as outlined in this program.

In all three indications, the child would not benefit sufficiently from outpatient psychiatric treatment. Examples of such children might be: a severely withdrawn schizophrenic child; a very anxious, ritualistic, compulsive child; an aggressive, destructive, "acting out" child; or a depressed, inhibited child.

A purpose of day care rather than residential care for such children is to enable them to maintain contacts with their own homes and communities. The hope is that the family can be rehabilitated and provide a more constructive environment for the child. Such a goal requires that the program provide appropriate treatment for the parents. The program also offers maximum community contacts as compared to the isolation of the average residential treatment center.

The center would provide three major therapeutic approaches to each child. These are:

1) Individual psychotherapy consisting of three or more interviews per week.

2) Individually planned and conducted remedial teaching.

3) A therapeutically planned play and group experience.

The actual operation of such a program is complex but can be described in outline as follows:

1) Up to fifteen children will be accepted, which, [sic] in the opinion of the center's staff, need this type of care.

2) They will be at the "Day Care Center" at the University of Colorado Medical Center during the whole day.

3) While at the center they will attend its school program within their capacity to use this experience productively.

4) They will be seen for psychiatric treatment one hour, three times weekly.

5) When not in school, their play and group activity will be closely supervised so as to be a part of a total therapeutic endeavor.

6) Significant family members or foster parents will be concurrently involved in the treatment program for the child.

A building for the "Day Care Treatment Center" would be designed in accordance with the over-all building program for the University of Colorado Medical Center. The physical plant would be located on Medical Center grounds. Some of the facilities needed would be: playground area, classrooms, rooms for hobbies and crafts, indoor play area for the children. For staff, there will need to be offices, conference rooms, and play therapy rooms. Though food will be prepared in the hospital kitchen, there should be an equipped kitchen for snacks and for cooking as part of play or school program. Construction would be sturdy, simple, and planning would utilize the experience of other similar programs. The yearly operating budget for the program is estimated as follows:

1)	Director - psychiatrist*	$ 18,000
2)	Administrative assistant	8,000
3)	Staff psychiatrist - part-time*	8,000
4)	Director of child care	7,000
5)	Teacher	7,500
6)	Clinical Psychologist	9,500
7)	Psychiatric social worker	6,000
8)	Pediatric care	4,000
9)	Laboratory fees and emergency hospital care	1,000
10)	Transportation - car or bus shared with Children's Diagnostic Center	2,000
11)	Secretaries (three)	10,500
12)	Food - daily lunch	4,000
13)	Books, recreational, and teaching supplies	2,000
14)	Pro-rated Medical Center administration costs	7,000
15)	Office supplies	1,000
	Sub-total	$ 95,500
16)	Social worker for foster home program**	5,000
17)	Foster homes for five children**	10,000
	Total	$110,500

*Estimated on basis of full-time academic appointment.

**Funds to be allocated to and administered by State Child Welfare Department.

Fees would be charged families in accordance with their ability to pay, and with an appropriate fee schedule.

State Children's Home

The study of the children's home made by the Child Welfare League resulted in a number of recommendations, the effect of which would be to: 1) limit admittances to the home; 2) reduce the present resident population; and 3) change the home's functions and programs. This study was presented to the Governor and members of the General Assembly in February, 1959. During the same legislative session, the General Assembly passed House Bill 504. This legislation limited the commitment of children under seven years of age to the home by providing that such commitments of dependent or relinquished children had to be approved by the superintendent of the home. The children's home is continuing to accept these younger children until its adoptive waiting list is exhausted.

Administrative action has also been taken to find foster and adoptive home placements for those youngsters already in the institution. The Child Welfare Division has been working with the home in this respect, but this approach has met with limited success because of the difficulty in placing these youngsters.

In the past the children's home has been a dumping ground for children (regardless of needs or problems) for whom local courts and/or social agencies were unable or unwilling to help or place in the community. Most of these youngsters are older (over 75 per cent are more than six years of age); many are members of minority ethnic groups; some have mental and/or physical handicaps, and, as might be expected, a number are emotionally disturbed. Any one of these factors makes placement difficult. A combination of two or more makes placement almost impossible.

For these reasons, it appears that the home population contains a "hard core" of youngsters who will not be placed and will therefore remain at the home until they are ready and of an age to return to society on their own. Special attention should be given to this group of youngsters with program planning aimed at helping them return successfully to society.[15]

Ultimately the population at the home should be reduced considerably. (The resident population decreased from 191 to 142 from July 1, 1959 to July 1, 1960.) This reduction should come about through more careful intake policies, placement of some of the present resident population, and as other residents grow up and leave the home to make their own way in the community.

Restrictive intake policies will be successful only if: 1) local services are improved to the extent that foster and adoptive placements can be found; and 2) local authorities are willing to assume this responsibility to a greater extent than they have in the past. Assuming that intake may be reduced successfully, the home should no longer receive pre-school children who do <u>not</u> need group care. This would result in the home having two different resident groups. The first would include those present residents who will not be placed. The second would include new commitments, who need a group care setting.

The children's home has an important position in an over-all mental health program, not only because of the therapy needs of the resident population, but because of the possibility of using the home ultimately for a complex of different types of facilities and programs for emotionally disturbed juveniles. The home has six acres of unused property located across the street from the home proper (East Iliff Avenue). There may also be a possibility in the future of using some of the present facilities. Should such

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15. The Child Welfare League study did not deal adequately with this problem. The assumption was made that all children not needing group care should and could be placed or should be transferred to other more appropriate institutions; e.g., mental defectives to Ridge.

use be made of the children's home, it is recommended by the Child Welfare League and local professional people that each facility and program have a separate treatment staff, although administrative and housekeeping functions could be handled by the present home administration.

Consideration should be given to use of the home for group care - limited therapy, residential treatment center, relocation of the Diagnostic Center, and perhaps day care and/or outpatient treatment. In examining these possibilities further, attention should be focused on the relationship between the proposed facilities and the Colorado Medical Center and the possibility of coordinating such facilities with the center's resident program.

As there appears to be little justification for proceeding with facilities for a children's mental health program at both Fort Logan and the children's home, a basic decision should be made as to which location should be used. It would seem more desirable to separate adult and children's facilities, if at all possible.

Golden and Morrison

Both institutions still make use of the Children's Diagnostic Center, but to a lesser extent than in previous years. During the period from September 1, 1959, to September 1, 1960, there were only eight referrals to the Diagnostic Center from the boys' school and none from the girls' school. During 1958, there were 11 referrals from the boys' school and 26 from the girls' school. The decline in the number of referrals may be traced in part to the increase in professional staff and services provided at the two institutions.

The girls' school now has the part-time services of a psychiatrist; a full-time clinical psychologist and social worker on the staff; with a rehabilitation counselor supplied by the Department of Rehabilitation. A building recently completed serves as a treatment center for a maximum of 25 girls. The program at the boys' school has been augmented through the addition of a clinical psychologist, a psychometrist, a sociologist, and a rehabilitation counselor. The boys' school also has the services of a part-time psychiatrist.

Even with these improvements, both schools need further expansion in therapy, diagnosis, and evaluation.

Fort Lewis A & M Campus at Hesperus

There has been considerable interest expressed, especially by San Juan Basin residents, in using the old Fort Lewis A & M campus at Hesperus for some type of rehabilitative facility for juveniles. Judge James Noland, 6th Judicial District, Durango, has proposed that the Hesperus campus be used for what he termed

an in-between group of youngsters whose home environment is unsatisfactory. Rather than commit these juveniles to a correctional institution, Judge Noland recommended an open facility similar to Boys' Town, with group care combined with a farm and forestry program.

Others have proposed a series of C.C.C. type forestry camps for delinquents, one of which might be located at Hesperus. The Children's Laws Committee considered the possibility of establishing a small facility for 35-40 youngsters who could benefit from a group care program in an outdoor setting and who might need outpatient psychiatric therapy, which could be purchased on a contract basis from the new San Juan Basin Mental Health Clinic.

The State Board of Agriculture, which currently controls the Hesperus property, has indicated its willingness to make available the buildings in the campus quadrangle plus surrounding land not to exceed 160 acres for a youth program as long as delinquents are not involved. This limitation in area and the board's opposition to having the property used as a facility for delinquents present obstacles to the establishment of a forestry-farm camp at the Hesperus campus.

Cost of Renovation

At the request of the Children's Laws Committee, the State Planning Division inspected the Hesperus campus to determine the cost of renovation. As a result of this inspection, the planning division estimated that it would cost approximately $126,500 to restore the usable buildings and repair the water, sewage, heating, and electrical systems. This estimate does not include either the alterations necessary to convert buildings to a new use or furniture and similar items.

On the basis of the planning division report, it would cost at least $50,000 (and perhaps as much as $90,000 if the entire water system would still have to be renovated) even to repair and remodel those buildings which would be necessary for the limited program considered by the Children's Laws Committee.

Durango Meeting

The committee met in Durango on July 8, 1960 to inspect the Hesperus campus and to meet with those San Juan Basin citizens interested in using the campus for some sort of youth program. The sentiment expressed at this meeting was generally in favor of Judge Noland's proposal; although some of those present, including Judge Noland, were willing to accept the more limited plan considered by the committee as a first step in a large scale rehabilitation center.

The San Juan Basin Indian tribes were represented at the meeting and favored Judge Noland's proposal while objecting strongly to a limited group care facility with limited outpatient therapy. There were two reasons for this objection: First, the

tribes have an excessive drinking problem with many youngsters and look upon Judge Noland's proposal as a possible solution. Second, at least one of the tribes has an arrangement with Colorado General for psychiatric services. The reaction of the Indian tribes to proposed uses of the Hesperus campus is important, because the Congressional acts which conveyed this property to the State of Colorado specify that Indians must have free and equal access to any institution or facility constructed and maintained thereon.

The Children's Laws Committee decided not to recommend any specific proposal for the use of the Hesperus property at this time. There were several reasons for this decision: 1) There is no general agreement among those concerned as to the type of facility which should be established. 2) There is no way of determining as yet what type of facility would best fit in with the over-all institutional and mental health programs. 3) There would be considerable expense involved in remodeling and repairing the Hesperus campus buildings in addition to operational costs, which would be at least $1,500 to $2,000 per capita and might even be more, and there is some question whether the General Assembly would be willing to finance a new program to this extent in view of the circumstances cited in 1) and 2) above.

FURTHER PROGRAM NEEDS FOR EMOTIONALLY DISTURBED JUVENILES

There have been some advances made in programs and services for emotionally disturbed juveniles during the past two years, but many needs are as yet unmet and some existing programs require further improvement. Provision of many of the needed services will undoubtedly have to await the development of an over-all state mental health program; however, some improvements in existing programs and services can be made more immediately.

Residential Treatment

One of the most vital services needed for emotionally disturbed juveniles is residential treatment. Residential treatment is also the most costly of psychiatric services. The American Psychiatric Association recommends that the maximum unit size should be 20 to 25 beds in order to provide the best treatment, although it would be possible to have several of these self-contained units within the same institution. Construction costs of one of these units is estimated at $200,000 or more, and operational costs are estimated at $10,000 per bed annually or $250,000 for a 25-bed unit.

Availability of Personnel

There is an acute nation-wide shortage of trained child psychiatrists and psychologists. Some prefer to remain in private practice, and the competition among states for those interested in public service is keen. Even with a more competitive salary scale, the shortage makes it doubtful that a sufficient number could be recruited to staff anything but a small inpatient treatment center without causing gaps in other levels of service.

Number of Juveniles

The cost of constructing and operating even one 20-25 bed residential treatment unit makes it unlikely that it would be financially possible for the state to build enough units in the immediate future to meet demands for this kind of treatment. It would cost at least $800,000 to build enough units to take care of 100 juveniles at an annual operating cost of $1,000,000. Patient turnover in residential treatment units is slow, because many youngsters may have to spend from two to five years before they are ready to return to society.

The case histories of most of the youngsters for whom intensive inpatient treatment is recommended show that they have been emotionally damaged over a period of several years. This indicates that either they haven't received any treatment or that the treatment received was incorrect or insufficient. In other words, the

sooner an emotionally disturbed youngster is identified and diagnosed, the greater likelihood that outpatient treatment, foster home placement, or case work services will suffice.

Since it is desirable to reach these youngsters as soon as possible, it can be argued that the initial emphasis in developing a comprehensive program for emotionally disturbed juveniles should be placed on providing the services such as community mental health clinics which will reach the greatest number of youngsters at the earliest possible time. Nevertheless, the needs of severely disturbed juveniles cannot be long ignored despite the cost and personnel recruitment problems.

The decision as to how rapidly residential treatment facilities for juveniles should be constructed and how many youngsters are to be provided for should be made within the context of a total state mental health program in order to assure balanced development of mental health services and proper allocation of financial resources and personnel. A further problem is the location of residential treatment facilities for juveniles; as indicated earlier in this report, there has been a difference of opinion, with both Fort Logan and the State Children's Home under consideration as possible sites. Again this is a decision that can best be made by taking into account other mental health program plans.

Day Care Treatment

Day care treatment offers several advantages over residential treatment for those emotionally disturbed youngsters who are not so seriously disturbed that residential treatment is the only possibility. Day care treatment is less expensive, because the patients spend only eight hours per day at the treatment center, rather than 24, requiring fewer staff members. Those undergoing day care treatment are not completely isolated from home and community environments, as they would be in residential treatment. This is beneficial because it allows youngsters to retain ties with their families and associates. Through consultation with parents the home situation can be improved and parents assisted in dealing more adequately with their emotionally disturbed offspring. Foster homes can be provided for those youngsters whose home situation is undesirable, although it is difficult to find adequate foster homes for disturbed youngsters.

The proposal by the Colorado Medical Center for a pilot unit day care center is a positive step in the development of services for emotionally disturbed juveniles, in the opinion of the Children's Laws Committee. The training and research which could result from the operation of this pilot day care center should be of great value. However, the services which will be provided will reach only a very small number of those youngsters who need help.

It would be highly desirable if eventually a series of day care centers could be established around the state, possibly in conjunction with community mental health clinics; but it is premature to consider such a far-reaching project at this time, when community mental health clinics are not nearly developed to the extent necessary.

Community Mental Health Clinics

There has been considerable advancement in the past two years in the provision of community mental health services, both in the establishment of new clinics and the expansion of programs in some of the existing clinics. These advances represent a solid foundation upon which to develop the extensive community clinic program which is needed. Several areas of the state still do not have access to community clinic services, while in other areas, clinics operate only on a limited part-time basis. These areas include the San Juan Basin, San Luis Valley, Glenwood Springs and surrounding counties, Northeast Colorado, Eastern Colorado, and the Arkansas Valley.

While community clinical services are needed for juveniles, it is most important that these services not be so limited. The development of an adequate clinic program should encompass both adults and juveniles. The clinics should also be coordinated closely with the institutional program to provide: 1) a means of controlled referrals; and 2) after-care treatment. After-care treatment should not be limited to patients released from psychiatric facilities, but should be extended as well to adult and juvenile parolees in need of outpatient treatment. Nor should clinical services be limited merely to diagnosis, evaluation, and therapy of patients. The clinics should be staffed with trained case workers who can consult with families, schools, etc., in conjunction with the work with patients.

Until the basic decision is made as to which state agency is to have the responsibility for administering standards and state assistance, it is doubtful that a sizeable increase in state aid will be provided. Consequently, any significant expansion of the community clinic program in the next two years may depend entirely on increased local effort.

Golden and Morrison

A significant proportion of the juveniles committed to Golden and Morrison are known to be emotionally disturbed. Some of these were committed because there were no other resources available. In the past, the institutions have not had either the professional personnel or the facilities to develop a program which would help this group of delinquents. Considerable improvement has been made in the past two years, but additional steps are necessary to provide an extensive treatment-oriented program.

There are two major reasons why concentration on a treatment-oriented program is necessary at the two juvenile institutions: First, all of the youngsters committed to these institutions will be released in a relatively short period of time. Little will be gained from these commitments, if all possible effort is not directed toward making a successful return to society. Second, there is little justification for the state to provide costly inpatient treatment for youngsters who might have been helped at less expense in the two institutions.

Other Needs and Programs

Emphasis should not be placed on the development of diagnostic and psychiatric treatment services to the extent that related functions are ignored. The courts, the schools, probation and parole departments, and welfare agencies all play an important role in working with the emotionally disturbed juvenile. Usually it is one of these agencies which has the initial contact with the emotionally disturbed juvenile, makes the preliminary evaluation, and refers him for professional diagnosis and treatment.

In many instances these agencies are also involved in the treatment program; for example, case work services and foster home placement are provided by the welfare department, the two juvenile institutions have the opportunity to provide treatment during the period of commitment, and schools may provide counseling and special education programs.

Treatment is not limited to professional psychiatric and psychological services. In the broadest sense, it involves almost everyone who comes in contact with the juvenile during the time in which his problems prevent him from becoming a productive member of society. For this reason it is important that: 1) judges have a knowledge of the problems involved and courts be staffed with a sufficient number of qualified probation officers; 2) schools be staffed with psychologists and case workers; 3) juvenile parole officers be qualified and have manageable case loads; and 4) welfare agencies have sufficient personnel to provide case work services and find additional foster homes.

Juvenile Parole

The Juvenile Parole Board has been confronted with the problem of finding adequate placement for boys and girls eligible for release. The alternatives are either to keep them at the institution for an additional period or to return them to the same environment which resulted in their commitment; neither of which is satisfactory. Dr. Ellis Graham, Chairman of the Juvenile Parole Board, has proposed that consideration be given to the establishment of half-way houses in various parts of the state, where a small number of youngsters (4-8) may reside with carefully selected house parents, and either work or attend school.

In addition to finding adequate house parents, one of the major obstacles in setting up a half-way house program is community acceptance. Three group foster homes have been established by the Department of Welfare in Pueblo, Boulder, and Weld counties. In both Pueblo and Boulder counties, there has been adverse community reaction because one youngster in each home committed a delinquent act. As a consequence of this reaction, the other youngsters have been singled out, and there is a tendency to blame them for delinquent acts for which they may be completely innocent.

If community resistance is overcome and the funds are appropriated to establish half-way houses, it would be useful to have these homes tied in with the community clinic program, so that outpatient treatment might be available, as well as consultation for the house parents.

Central Diagnostic Facility

If and when additional juvenile facilities are established, such as forestry camps and group care homes, it would be extremely desirable to have a central screening facility to which all juveniles committed by the courts would be sent. After testing, diagnosis, observation, and evaluation, a determination could be made as to the proper facility and program for each juvenile. Under this arrangement the courts would commit juveniles to the agency responsible for screening rather than to a specific institution.

The agency which should have this responsibility can be determined with more certainty after a final decision is reached concerning the organization of the institutional and mental health programs. If the prime responsibility for these programs remains with the Department of Institutions, it would be the proper agency for this function, with the responsibility for assignment of juveniles perhaps given to the Juvenile Parole Board.