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0159 Mental Health and Mental Retardation

Colorado Legislative Council

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Report to the Colorado General Assembly:

Mental Health and Mental Retardation

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 159

November, 1970

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OF THE

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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.

MENTAL HEALTH
AND
MENTAL RETARDATION

Legislative Council

Report to the

Colorado General Assembly

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COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 46 STATE CAPITOL
DENVER, COLORADO 80203
892-2285
AREA CODE 303

November 20, 1970

To Members of the Forty-eighth Colorado General Assembly:

In accordance with the provisions of House Joint Resolution No. 1034, 1969 Session, the Legislative Council submits for your consideration the accompanying report pertaining to mental health, mental retardation, special education, and drugs and alcohol.

The Committee appointed by the Legislative Council to conduct the two-year study reported its findings and recommendations to the Legislative Council on November 20, 1970. The Council adopted the report at that time to be transmitted with favorable recommendation for consideration by the First Regular Session of the Forty-eighth Colorado General Assembly.

Respectfully submitted,

/s/ Representative C. P. (Doc) Lamb
Chairman

CPL/dlh

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 46 STATE CAPITOL
DENVER, COLORADO 80203
892-2285
AREA CODE 303

November 12, 1970

Representative C. P. (Doc) Lamb
Chairman
Colorado Legislative Council
Room 46, State Capitol
Denver, Colorado

Dear Mr. Chairman:

Pursuant to House Joint Resolution No. 1034, 1969 Session, the Interim Committee on Mental Health and Mental Retardation submits the following report for consideration by the Legislative Council. The Committee's findings and recommendations are the result of nearly seventeen meetings during which the Committee considered the problems and programs in the four major areas of mental health, mental retardation, special education and drugs and alcohol.

Respectfully submitted,

/s/ Senator Ruth Stockton
Chairman
Committee on Mental Health
and Mental Retardation

RS/dlh

FOREWORD

House Joint Resolution No. 1034, 1969 Session, directed the Legislative Council to appoint a committee to study the prorams of mental health, mental retardation, special education and drugs and alcohol. The following members of the General Assembly were appointed to serve on the Interim Committee on Mental Health and Mental Retardation:

Sen. Ruth Stockton, Chairman	Rep. Sandy Arnold
Rep. Roy Shore, Vice-Chairman	Rep. Joe Calabrese
Sen. Hugh Chance	Rep. Tom Grimshaw
Sen. Chet Enstrom	Rep. Paul Hamilton
Sen. Allegra Saunders	Rep. Dick Lamm
	Rep. Kay Munson
	Rep. Floyd Sack

House Joint Resolution No. 1034 charged the Committee to study:

(1) mental health and mental retardation problems and programs;

(2) protective services;

(3) alcoholism, drug treatment and prevention, education and rehabilitation of alcohol and drug users;

(4) federal, state, and local financing and the formula for support of programs;

(5) and the coordination of programs, and their relationship with comprehensive state health and special education programs.

The first year of Committee activities focused on providing an opportunity for those state and local officials, private organizations and the general public to appear before the committee to comment on Colorado's mental health, mental retardation, and special education programs. The Committee made several visits to various state and private facilities providing programs for mental health, mental retardation and special education.

During the second year of study, the Committee continued its examination of the mental health, mental retardation and special education programs including the methods and problems in funding and the coordination of these programs. In addition, pursuant to Senate Joint Resolution No. 21, a Task Force on Drugs

and Alcohol was appointed to advise the Committee in its study of alcoholism and drug abuse. Those comprising the Task Force were from a variety of fields, and the membership represented a broad spectrum of age, ethnic groups and geographic location. For example, included in the membership of the Task Force were representatives of private agencies, former drug users, high school students, as well as doctors, clergymen and others. The purpose of the Task Force was to provide information to the Committee about what is currently being done in the areas of drugs and alcohol and to make suggestions and recommendations to the Committee as to the kind of approach needed from the state government and the kinds of programs needed for alcoholics and drug abusers.

The Committee wishes to express its appreciation to the members of the Task Force who are listed below:

Mrs. Connie Anderson
Judge George Armstrong
Mr. Luke Austin
Mr. Reg Bessette
Mr. E. J. Blackburn
Mr. Dave Canaday
Lt. Walter Chin
Dr. Donald Cook, M.D.
Dr. Henry Cooper,M.D.
Mr. Tom Cooper
Dr. Mildred Doster,M.D.
Mr. James Fesler
Reverend John R. Graham
Mr. Ed Hart
Dr. Stuart Hollingsworth,M.D.
Mr. William I. Israel
Mr. Lee Kaiser
Dr. Roy Krosky
Dr. Peter Manes,M.D.
Mr. James McMearn
Dr. Thomas Miller,M.D.
Mr. John S. Mrozek
Mr. Jay Pieratt
Mr. Robert Rundle
Mr. Don E. Shaw
Mrs. Betty Smith
Reverend Errol Stevens
Mr. William C. Stover
Mr. Edward Vigil
Mr. Tom Waddill
Mrs. Betty Jo Woods
Dr. Roland Zarlengo,M.D.

The Committee also wishes to acknowledge the contributions of representatives from the Division of Special Education, Department of Education; Division of Alcoholism and Drug Abuse, Department of Health; Division of Mental Health and Division of Mental Retardation, Department of Institutions; Division of Public Welfare, Department of Social Services; the Association for Mental Health; Colorado Association of Mental Health Centers and Clinics; Colorado Association for Retarded Children; and the State Association of Community Center Boards.

Becky Lennahan, Legislative Drafting Office, provided the Committee with bill drafting services. Kay Miller, Research Associate, had primary responsibility for the preparation of this report, assisted by Dorothy Jakelsky, Research Assistant, Legislative Council staff.

November 1970

Lyle C. Kyle
Director

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COMMUNITY MENTAL HEALTH PROGRAMS

In 1964-65, the State of Colorado allotted 25 cents per capita (based on population served) to community mental health clinics for outpatient and consultive services. This figure doubled in five years, and in 1970-71 the state is allocating 60 cents per capita for clinic services. Furthermore, the growth in state expenditures for community mental health services may be even greater in the 1970's. For instance, the Boulder and Southwest Clinics are in the process of changing from clinics, which offer out-patient and consultive services, to comprehensive centers. Basically, this simply means that 24-hour emergency services and in-patient care will be made available. Consequently, the cost of operation of these community programs will increase sharply. The per capita cost of the Boulder clinic for 1970-71 is estimated to be $1.28. In the first year of operation as a center, 1971-72, per capita costs are expected to rise to $5.60. Although the federal government finances the major portion of center expenditures in the first few years of operation (75 percent of approved staff salaries the first two years), the state is expected to assume the burden as the federal share declines. The third year of activity, federal funding amounts to 60 percent; the fourth year -- 45 percent; the fifth and subsequent years of a community center program, federal funding declines to 30 percent; and ends altogether after eight years. The total estimated expenditures of eight comprehensive mental health centers -- Adams, Arapahoe, Boulder, Denver General, Jefferson, Midwest, Southwest, and Weld -- for fiscal 1971-72 is over $6.9 million.

Relationship of Community Programs to State Government

The projected demands on state funds for community mental health services are focusing increased attention on the organization, operation, and types of programs provided by clinics and centers. The community clinics and centers are not agencies of the state but are governed by their own local boards. Membership on community boards varies from center to center. Although community programs must be approved for state funding, the Department of Institutions does not exercise direct control over staffing patterns and salaries. Furthermore, program emphasis varies from center to center, depending on staff orientation and the needs of the communities involved. Some clinics emphasize direct services (individual and group therapy, for example), while others believe that consultive programs provide the most outreach into the community. Finally, there is a tremendous variation in program costs: rural areas are harder to serve than urban areas because of travel time involved or need for local offices; poverty area clinics are handicapped because of the difficulty in obtaining local funds; fewer social agencies and auxiliary services are available in rural areas, suggesting that

the relative mental health load of rural clinics may be greater than in urban areas.

At the April 29, 1970 meeting of the Committee, members of the Joint Budget Committee and staff expressed additional concern that the General Assembly is being asked to fund local community mental health programs, even though the General Assembly did not approve the establishment of specific clinics and centers. Also, the funding of clinics and centers, particularly with respect to the per capita grants for out-patient services, is not based upon caseloads, kinds of services provided, the quality of programs or other measures of service to people.

In view of the aforementioned concerns, the Committee considered alternatives to the present programs including: 1) a state administered program; 2) a requirement that all boards be operated under the direction of elected county or city officials; 3) a mandatory local tax for support of clinics and centers; and 4) state purchase of services based on individual treatment rendered. The Committee rejected all of these proposals for the following reasons:

(1) The Committee totally rejects the concept of state administration of community mental health programs. The Committee believes that active participation of the community is essential, because mental health programs must involve law enforcement agencies, welfare, schools, and other local programs and resources. Furthermore, the flexibility of existing community programs would tend to be destroyed if dominated by a central state office. In the event that a local clinic or center fails to meet state standards, state support can be withdrawn. State administration is not a necessary ingredient to effective utilization of state dollars.

(2) The Committee believes that the provisions of 3-11-11 (1) (f), C.R.S. 1963, as amended, providing standards for the makeup of community boards is adequate. The state of Colorado should not go any further in dictating the organization of community boards which could jeopardize present citizen interest in fostering community mental health services.

(3) A mandatory tax levy would not meet the needs of poverty areas and other communities hard pressed for funds. Local communities are already providing monies through contracts with school districts and on a voluntary basis through the county general fund. The Committee believes that each local community should make the determination as to the level of tax support that it will make to support a clinic or center.

(4) It is the belief of the Committee that purchase of services, similar to state administration, would tend to minimize the flexibility in existing programs. There could be a tendency to support the type of activities which are easily re-

corded on accounting forms. Emphasis would probably swing to the provision of direct services as opposed to services that are harder to measure such as consultive programs. Furthermore, the purchase of services would not enable a clinic or center to be insured of a stable source of funds upon which it could base its budget. Finally, it would be far more difficult for a center to change direction and attempt to establish new types of services. If a program did not work out as planned, funds would not be available to meet expenditures and to finance alternative services.

Proposed Amendment to Colorado's Community Mental Health Law

Clinic Funding. The Committee recommends that Colorado's community mental health law (3-11-9 to 3-11-11, C.R.S. 1963, as amended) be revised but certain basic concepts be retained. Specifically, the Committee supports continuation of the existing organization of the community center and clinic boards. The Committee also believes that the state funding of clinics on the basis of population served (the present per capita grant program) should be retained. Per capita grants provide a relatively simple method of controlling the budgets of clinics without the necessity of detailed monitoring of programs by the Department of Institutions and executive and legislative budget agencies. The Committee believes that per capita funding insures flexibility in community programs, while permitting the General Assembly to determine a relative measure of state effort for the support of local mental health clinics.

Funding Community Centers. The community center programs are designed to provide comprehensive mental health care. Some of the centers are serving specified catchment areas, while others are providing specialized services (for example, the Denver Children's Hospital) for the entire state. Because of the variety of levels in federal staffing grants for these programs, state contributions must be flexible to meet the needs of individual centers. The Committee recommends that the state of Colorado discontinue per capita funding for centers and provide funds for each approved center based on the availability of federal and local funds and according to services provided. In determining the appropriation for the community centers, the General Assembly (Joint Budget Committee) should review the individual budget requests of all the centers. The final allocation of state funds, however, should be at the discretion of the Executive Director of the Department of Institutions.

Since the Committee is recommending deletion of any per capita funding for community centers, steps need to be taken to provide effective program evaluation to insure that there will be a reasonable allocation of the state's resources for the community centers. The community centers work in close cooperation

with state institutions and contract for "back-up" services. With the additional growth in community centers, the relationship of state operated facilities to local programs becomes more critical.

In July of 1968, the patient load at the state institution at Fort Logan numbered about 550. This patient load has decreased to a little over 400 in September of 1970. The decrease in caseload is surprising, since the institution's budget is based on an estimated caseload of 635 for Fiscal Year 1970-71. Although the reasons for the decrease are not known, perhaps the unexpected change in caseload illustrates existing and future problems of integrating state and local services, especially as community programs become more sophisticated.

For these reasons, the Committee recommends that the Executive Director of Institutions be charged with responsibility for specifying levels and types of in-patient, out-patient, consultation, education, and training services and expenditures, as well as other programs of community mental health centers that are to be supported from state monies. The purpose of this recommendation is to emphasize the need for greater coordination of mental health programs.

Finally, the Committee believes that the Department of Institutions should be provided with additional funds for the purposes of developing innovative programs, meeting contingencies, and financing some of the local share of expenditures of clinics and centers servicing impoverished areas. Innovative programs would be aimed at those target populations that are not now presently reached with current direct and indirect services. Contingency moneys are to be used for such crisis situations as alcoholism, drug addiction, and adolescent adjustment difficulties. Innovative and crisis programs should be clearly defined in terms of services to be rendered, project objectives, scope and duration of the program, and the amount of funds to be provided. Any such allocation of funds should be approved by the Executive Director of the Department.

Evaluation of Community Mental Health Programs

The community mental health concept is fairly new in Colorado. The first comprehensive Colorado plan for community mental health facilities was completed as recently as 1965. The first federal funding was available to community mental health centers with the passage of P.L. 88-164 -- "The Community Mental Health Centers Construction Act of 1963". As with any new program, there is a need for evaluation to determine its effectiveness.

The Department of Institution officials and community centered personnel are attempting to develop information on programs that will be meaningful, but when this data is considered in both the executive and legislative budget processes, there appears to be a breakdown in communication. Consequently, the state of Colorado may not be getting the most effective allocation of state monies for mental health activities. Community centers, in particular, have recognized that they do not have the expertise or personnel to do an adequate job of program evaluation. Further evaluation by departmental personnel is needed to provide objectivity and comparisons among programs.

The Committee recommends that the Department of Institutions provide meaningful caseload figures for center and clinic programs developed from a useful measure of average service hours, average daily enrollment and/or attendance. Program and financial standards used in allocating funds to community centers and clinics by the Department of Institutions must be provided to the General Assembly with sufficient detail for analysis and review.

Department personnel should be specifically assigned to answer the kinds of questions asked and collect the sort of data required by the General Assembly and others in making decisions concerning financing of mental health facilities. Other members of the departmental team should be capable of evaluating programs in terms of techniques and methods. While this type of evaluation would be beneficial to the General Assembly, it would be particularly helpful to the facilities themselves in improving upon their own programs.

COMMITMENT

Under the present law concerning commitment of the mentally ill, a person alleged to be mentally ill, against whom a petition is filed in court, stands the chance of being hospitalized for a period of up to six months or committed to a state institution for an indefinite period of time. Many supporters of the commitment law and procedure believe it has adequate safeguards to insure that a person is not "railroaded" into hospitalization or commitment. However, the Committee believes that more steps need to be taken to prevent persons from being unnecessarily and unjustly committed or hospitalized. The Committee's concern is not only with protecting individual rights but also in insuring that our hospitals and institutions are not crowded with persons who cannot benefit from the care and services offered.

The Committee recommends that the commitment law be rewritten to establish a different procedure for civil commitment of mentally ill persons and to outline specifically the rights of the person for whom commitment is sought. The following problem areas were outlined to the Committee and may need to be considered by the General Assembly in any discussions concerning the commitment law.

Emergency Procedures. Under current law, the only person authorized to take a mentally ill person, who is dangerous to himself or others, into custody is a sheriff or police officer. Peace officers are sometimes reluctant to take persons into custody because there is no protection for the policemen against suits for false arrest if the person is later found not to be mentally ill. Also, policemen do not feel competent to make a judgment as to whether a person is mentally ill and should be taken into custody. Perhaps the authority to take a person into custody could be extended to mental health professionals in facilities designated by the Director of the Department of Institutions.

Period of Evaluation. It has been suggested that each commitment proceeding begin with a short period of evaluation, perhaps 72 hours. This could be initiated upon petition of an individual or through the emergency procedure described above. The purpose of the evaluation would be to determine whether the person needs further care and treatment and whether treatment will be accepted on a voluntary basis. Such evaluation could be a multi-disciplinary approach of looking at the problem -- the medical, psychological, social, family, financial and legal conditions that constitute the problem. The evaluation could be initiated by the emergency proceeding previously described or by a court order for such evaluation. Facilities providing evaluation services should be approved and designated by the Executive Director of the Department of Institutions, and qualified mental health centers could be used as facilities for evaluation.

Short-term Intensive Treatment. A person should be able to be certified for short-term intensive treatment only after an evaluation has been conducted and the evaluation team has determined that the person is mentally ill and, as a result, dangerous to himself or others or gravely disabled. The person should also have been advised of his right to voluntary treatment and refused such voluntary treatment. The period of treatment probably would not exceed three months but could be extended to six months if the treatment staff determines that further treatment is required. Perhaps there is no need for a court order in every case of short-term treatment, but the court should be notified, a legal counsel for the patient appointed, and the patient informed of his right to request a hearing before the court or a medical commission.

Long-term Involuntary Treatment. Long-term treatment is a final step in the commitment procedure and should be initiated following short-term treatment and after it has been determined that continued care is necessary. A provision probably needs to be made that as soon as the patient has improved sufficiently for him to leave or he is prepared to accept voluntary treatment that the professional person in charge of the treatment facility shall discharge the patient and notify the court.

It has been suggested that the professional person in charge of the treatment facility where the person has been held for six months should petition the court for long-term involuntary treatment. A second suggestion is that every petition for long-term treatment be reviewed by a court-appointed medical commission. However, any such medical commission should only have the authority to advise the court, and its recommendations should not be binding upon the court. The court could then make the final decision as to whether the request for extended involuntary treatment is warranted or the person should be discharged.

Periodic Review. Under present law, when a person is involuntarily committed under the long-term commitment provisions of the statutes, he is placed in the hands of institutional administrators and cut adrift from the legal process, which, for all practical purposes, takes no further interest in him. Because it is possible that a committed person could become a forgotten person as far as the legal system is concerned, adequate safeguards need to be written into the law to insure that each case will be given periodic review. It has been suggested that the original order for long-term treatment should expire after six months, and no extension of an order for long-term involuntary treatment should be for a period of more than one year. Each petition for an extension of an order for long-term treatment probably should be treated as an original petition, requiring a hearing before a medical commission and court review.

Distinction Between "Care and Treatment" and Hospitalization. Traditionally, a person who is committed is sent to a state hospital or private sanitarium for care and treatment. A person being treated involuntarily should receive care and treatment from whatever facility and in whatever form best meets his individual needs. The patient may receive the best treatment for his problem at a mental health center, on an outpatient basis, even though the treatment is not at the request of the patient. It has been suggested that any new commitment law should be flexible enough to allow treatment at any number of facilities. For example, an older, senile person may need the kind of care and treatment available at a nursing home but may not require the kind of expensive care that is offered at the state institutions. Such flexibility would allow the courts to assign persons to various kinds of treatment facilities which will best meet their needs. Such flexibility of choice would also prevent the courts from assigning people unnecessarily to state institutions to receive care they do not need.

Elimination of "Blanket" Adjudication of Incompetency. Under present law, an adjudication of incompetency serves as a blanket judgment of incompetency for all legal purposes. Persons testifying to the Committee questioned the validity of this procedure and pointed out that while a person may be incompetent to exercise certain of his legal rights, he may be perfectly capable of exercising others. For example, a person under medication may be incapable of driving a car, but he may be capable of making rational decisions concerning voting, the signing of contracts, etc. Under present law a person who is involuntarily committed on a long-term basis automatically loses all his rights and must secure a court order before his rights may be restored.

Perhaps the court should be required to make specific findings concerning each right or portion of liberty which a person is alleged to be mentally incompetent to enjoy. The court would consider each specific right when acting to deny or restore an individual's rights.

Conservatorship. It has also been suggested that the same philosophy outlined above should apply to the law governing court proceedings when a legal guardian is appointed for a person deemed gravely disabled. Under present law, a person must be adjudicated incompetent before a conservator can be appointed. The question has been raised whether it is just that a person should be denied all of his rights simply because he is unable to manage certain of his own affairs, for example, his finances. Those rights which relate to matters which are to be assigned to the conservator could be denied the disabled person, but the person should not lose all of his civil rights without the court ruling separately on each of these rights.

Legal Counsel for the Person for Whom Commitment Is Sought. Many attorneys argue that the greatest single need from a due process standpoint in the commitment proceedings is the need for every person receiving treatment involuntarily to be furnished with effective counsel. They contend that the role of guardian ad litem, as presently defined, does not adequately fulfill this function. One reason is the vagueness of the statutes in outlining the duties of the guardian ad litem. For example, the existing statute requires that the guardian ad litem make such investigation as may be necessary to protect the interests of the patient he is representing. However, the law does not spell out what the interests of the respondent are or what kind of investigation is adequate in such cases. In an attempt to remedy this situation, it has been recommended that the role of counsel as advocate for the patient be spelled out in greater detail in the statutes. For example, the law could spell out that the guardian's investigation should include the verification of the allegations contained in the notice of certification, interviews with family members and the person requesting the evaluation, etc.

Specific Rights of Patients Spelled Out by Statute. Finally, it has been suggested that all of the rights which a patient is to have while he is subject to involuntary treatment should be spelled out by statute. These rights could include: the right of appellate review of any order of long-term involuntary treatment; the right of a patient to petition for a writ of habeas corpus, questioning the cause and legality of his detention and requesting the court to order his release; the right to counsel; right to treatment; the right to privacy; the right to make phone calls and receive visitors; and the right to receive and send mail.

Mandatory School District Assistance to Community Center Programs for Trainable Mentally Retarded and Seriously Handicapped

Traditionally, school districts have not provided programs for trainable mentally retarded and seriously physically handicapped youngsters. Often the types of programs these youngsters need are far different from programs offered in a normal school curriculum. Apparently public schools have not developed the expertise, or the equipment, or the trained teachers, etc., to provide programs for these severely retarded and handicapped children. Whatever the reason for the schools' reluctance to get into this area, this educational gap has been filled by local community boards which have established centers and are purchasing services for the retarded and handicapped.

Because local boards usually lack adequate funds to meet program expenses, many parents are required to pay part of the expense of their child's training. For example, reports from local boards indicate that parent fees accounted for $88,521 of the total 1969-70 cash expenditures of $2,216,748. These parents are already paying their share in local school taxes but are burdened with this additional expense because their children do not "fit" into the regular school programs.

Article IX, Section 2 of the Colorado Constitution states that "...a system of free public schools..." is to be established ... "wherein all residents of the state, between the ages of six and twenty-one years, may be educated gratuitously." The Committee believes that in light of this Constitutional requirement, local school districts have an obligation to the trainable mentally retarded and seriously handicapped.

The Committee therefore recommends that school districts in the state with resident handicapped children be required to contribute to the training of such school-age children enrolled in community center programs. The Committee recommends that school districts be required to contribute a per pupil amount which is equal to what the district spends in local monies for the education of a normal child. The Committee suggests this be accomplished by an amendment to Section 71-8-2, C.R.S. 1963, as amended, to the effect that each school district which has a child under 21 years of age enrolled in a community board program shall pay that board an amount equal to what the district spends in local tax monies for the education of a child enrolled in the district's regular school program. In other words, school districts should be obligated to provide local school monies for every child who, if normal, would be eligible for enrollment in the district's regular school program. The amount the school district should pay for each child enrolled in a community board program should be equal to the pupil amount raised

in the district by levies in the school district's general fund and the per pupil entitlement from the district's foundation levy.

The Committee recognizes that a great many school districts are already contributing to the training of children in community board programs. Some, in fact, are making cash and in-kind contributions that far exceed the amount they are spending for normal school children. The Committee commends the school districts which have recognized their responsibility to these children and voluntarily contributed to their training. However, other school districts have made little, if any, effort to assist the community center boards in providing programs for school-age handicapped children. The Committee believes that those districts which have been generous in their contributions are now being placed at a disadvantage because they are trying to provide as good a program for normal children as school districts which are making no effort at all to assist the community boards.

Also, there is a wide variation in community board programs between those receiving school funds and those trying to make it on their own and relying on parental support. One reason for this disparity in programs is that the state will match 75 percent of program costs. The local community must provide the other 25 percent matching funds. One center board with 100 enrollees may get school district support in the amount of $500 per enrollee. Even if this were the only means of local support, it would qualify the board for $150,000 in state funds making its total program budget $200,000. Another center board with the same number of enrollees which receives no assistance from local school districts may only be able to come up with $25,000 locally. This amount would qualify the board for $75,000 in state funds. Thus the two programs are attempting to serve the same number of persons, but one operates with a budget of $100,000, while the other has $200,000. The Committee believes its proposal would help to equalize the efforts made state-wide by school districts and provide an equitable approach to community boards for receipt of school funds.

Protective Services for the Mentally Retarded

Many retarded persons are able to function in a community setting but require some supervision and protection from exploitation. Parents and relatives of retarded persons often provide this protection when they are able but worry what will happen to their retarded relative when they die or can no longer care for them. If some substitute for parental care is not available for these people, the only alternative is to institutionalize these persons at a substantial cost.

In addition, there is a growing trend to move retarded persons out of institutions and into facilities in the community when they no longer need or can benefit from the expensive care offered by the insitutions. For example, Community Placement Program figures show that from April 1, 1969 to March 1, 1970, 215 retardates (165 adults and 50 children) were placed in community facilities. These retardates had all formerly been in one of the state facilities for the retarded -- at Ridge, Grand Junction, or Pueblo.

Under the present Community Placement Program the Department of Institutions extends social services to these people for one year after they are released from the institution. Many of the retardates who are placed in the communities qualify for Aid to the Needy Disabled and the county welfare departments provide certain casework services to them. But the welfare departments are restricted both legally and financially in the services they can provide.

Pilot Program for Retarded Persons. The Committee believes that a program of protective services should be made available for mentally retarded persons in need of such care. The Committee recommends that the initial program be a pilot program for the mentally retarded who have been released from a state institution or are on a waiting list for a state institution. It is estimated that the caseload for such a pilot program would be 450, and six additional persons on the state staff of the Department of Social Services would be necessary to conduct such a pro gram. These six positions would cost an estimated total of $69,000.

The Committee further recommends that after a year of operation of the pilot program, the Department of Social Services should make a report to the General Assembly. Such report would contain an evaluation of the success of the program, all relevant expenses, and projections concerning the cost of extending protective services to all eligible mentally retarded over 18 years of age.

SPECIAL EDUCATION

Mandatory Special Education

The Committee recommends that school districts be required to provide special education programs for those handicapped children in their districts needing such special attention. Under present law, school districts have the option of providing special education programs or not. If a school elects to offer a program, state funds are available to reimburse the school district for expenses for specified items such as teachers' salaries. Many people have argued that with adequate funds and other incentives, school districts can be encouraged to initiate special education programs on a permissive basis. However, the Committee finds that this has not happened in every school district in the state and that there are handicapped children in the state for whom there are no programs available and who are not receiving the special attention they deserve.

For example, the following table shows by program the number of school districts which provided special education programs in various categories for school year 1968-69.

Program	No. of Districts Participating	No. of Children
Aurally Handicapped	15	392
Educable Mentally Handicapped	75	7,116
Educationally Handicapped	53	3,160
Physically Handicapped	11	365
Speech Correction	62	17,127
Visually Handicapped	7	164
Home-Hospital	55	848
		29,172
Percent of Total School Population Enrolled in Special Education		5.66%

The Department of Education estimates that approximately 12 percent of the total number of children enrolled in schools have some type of handicap which would qualify them for special education. Using the Department's percentage figure, 33,086 school-age children or an additional six percent of the total enrollment in 1968-69 could have benefitted from special education programs.

The Committee believes that all children who are in need of special services should receive them. The General Assembly expressed its concern for providing programs for children with special needs by passing the "Handicapped Children Educational Act" which made state monies available for these programs. The Committee now believes there is need to go further to insure that the special needs of these children are being met.

The Committee recommends that legislation be adopted in the 1971 session that makes it mandatory that all school districts make special education programs available to the children named in the Handicapped Children Educational Act. Such legislation could require each school district to submit a comprehensive plan for implementing special education programs to the state Department of Education.

The Committee does not believe, however, that school districts should be required to provide pre-school programs for handicapped children if pre-school classes are not a part of their regular school program for all children. Consequently, the Committee recommends that any law mandating special education should clearly state that school districts would be required to provide special programs for children whose age would qualify them for enrollment in the regular school program in that district.

While the Committee believes that school districts should be required to provide special education, the Committee has serious reservations about the present method of state funding of special education as provided in the "Handicapped Children Educational Act of 1965." The Committee recommends that the General Assembly give serious consideration to developing a new method of state financing of special education in the 1971 session.

Additional State Monies for Special Education

The Committee recommends that the Handicapped Children Educational Act be amended to allow the state to reimburse school districts for part of the costs of equipment and instructional materials for special education. The Committee recommends that the state reimburse school districts for these items in the following manner:

Capital outlay - to be defined as materials and equipment costing over $100 and used

exclusively for special education. The state should reimburse 50 percent of the school districts' expenditures for these items.

Materials - to be defined as durable, reusable materials. The state should reimburse 50 percent or $200, whichever is less, for materials for each special education teacher in the district.

All of the items in these categories should be subject to the approval of the state Department of Education prior to reimbursement. As a condition for approval, each school district or Board of Cooperative Educational Services (BOCES) should maintain an instructional materials center wherein all special education materials and equipment can be placed and made available to all special education teachers in the district. A second condition for approval is that materials and equipment which are purchased in part with state funds and not currently in use by the school district or BOCES should be made available to other school districts in the state. The Committee believes that these conditions for approval would promote a system of state-wide sharing of special education materials and equipment.

To implement and expedite this system of state-wide sharing, the Committee recommends that the state Department of Education establish a central data bank in which all information concerning the location and description of the materials and equipment available to school districts could be housed. In this way, any teacher needing an item of special education material or equipment could phone the request in to the Department, and they could inform the teacher if such item is available and where.

Lowering Age for Children Served by Special Education

At present, the Handicapped Children Educational Act provides for state reimbursement for special programs for aurally and visually handicapped children and the crippled between the ages of three and 21. For the educationally handicapped and educable mentally handicapped the law limits reimbursable expenditures to programs for children between the ages of five and 21. The Committee believes that the educationally handicapped and the educable mentally handicapped children can also benefit from special attention at an early age. A "Headstart" type of approach, especially for identified educationally handicapped, might prevent the need for more intensive special programs later on when their handicaps become more acute or difficult to correct. Specifically, the Committee recommends that the Handicapped Children Educational Act should be amended to allow for reimbursement of expenditures of programs serving the educationally handicapped, and the educable mentally handicapped children between the ages of three and 21.

DRUGS AND ALCOHOL

One of the duties of the Committee on Mental Health and Mental Retardation was to study alcoholism, drug treatment, and prevention, education and rehabilitation of alcohol and drug users. In conjunction with its study and pursuant to the provisions of Senate Joint Resolution No. 21, passed in the 1970 Session, a Task Force on Drugs and Alcohol was appointed to assist the Interim Committee. The findings and recommendations that follow incorporate many of the proposals that were presented to the Committee by Task Force members.

Need for Establishment or Designation of a Coordinating Agency for Drug and Alcohol Programs

In the past, mental health agencies, the medical profession, and other state and local agencies have been reluctant to become involved in programs for alcoholics and drug users. A conference committee report from the Congressional Committee that developed the alcohol and drug provisions in the amended Community Mental Health Centers Act acknowledges this situation:

> Alcoholism and drug abuse are fields which have long been neglected by the medical profession. The alcoholic, or the drug abuser, is frequently an extremely difficult patient to deal with, and mental health professionals in general have shown considerably less interest in the problems of these patients than they have in the problems of other patients who are easier to treat.1/

Those few programs which have been developed to meet these needs have met with little success. For example, only about ten percent of those released from the federal facilities for drug addicts at Fort Worth and Lexington stay drug free for the first year after release. Some degree of success in dealing with drug users and alcoholics has been experienced by small-scale private facilities which are run and staffed by former users. However, there are limited numbers of these kinds of facilities and many of them are forced to close because of lack of adequate funds.

In recent years, the past year in particular, there has been a growth of interest in providing drug and alcohol programs. This interest has been sparked by the rapidly increasing use of drugs particularly among the college-age and young adolescents. For example, the State Hospital at Pueblo is requesting a substantial sum of state funds for a comprehensive drug program.

1/ U.S. Code Congressional and Administrative News, Conference Report No. 91-856, p. 369.

The Departments of Education and Health are working on a large-scale drug education effort financed by both state and federal funds. At the local level, the Boulder City and County Health Department is developing a comprehensive program for alcohol and drug counseling, education, and control.

In many cases, agencies seem to be dealing with the problem on a crisis basis rather than developing well-thought-out, long-range plans. Because of growth of these numerous programs which oftentimes appear to overlap and duplicate, the Committee believes the coordination and consolidation of the various efforts in the area of drugs and alcohol to be a number one priority in any state-wide effort in this area.

One voluntary attempt to coordinate some of the state programs has been through the cooperative efforts of the Departments of Education, Health, Institutions and Social Services. In 1966, an Interdepartmental Committee on Alcohol and Drugs was formed to take the leadership in bringing together the official state departments concerned with alcoholism and drug dependence in Colorado in order to stimulate comprehensive planning and a continuous review of programs and problems.

The Committee recognizes the limitations of the Interdepartmental Committee: the members have other staff functions in their respective departments; the committee is not in full-time operation; the committee does not have the authority to make rules and regulations for the coordination of various departmental activities in the fields of alcohol and drug abuse; and the committee has no direct mechanism by which to make suggestions or recommendations concerning program or budgetary matters to the General Assembly. The Committee also studied the functions of the Division of Alcoholism and Drug Abuse in the Department of Health to determine its role in the state's present approach to the alcohol and drug problem. Certain limitations appear to exist in the Division in terms of the extent of its statutory authority and in the coordination of state efforts relating to its duties. The Division is authorized to make studies and develop information concerning drugs and alcohol. The Committee envisions a state coordinating agency with much broader duties than this.

The Committee recommends that the Interdepartmental Committee be recognized statutorily as the official state coordinating agency for all drug and alcohol programs. The statute should outline the powers, duties, and functions of the Interdepartmental Committee. The Interdepartmental Committee should be responsible for developing a state-wide plan for alcohol and drug programs to include drug education, treatment, facility needs, etc. The plan should be revised annually, and upon the approval of the Governor, would be recognized as the official state plan for drug and alcohol programs. All drug and alcohol activities must comply with the state plan in order to qualify for state funds.

All programs which may involve any applications for federal grants should be subject to review by the Interdepartmental Committee. While the Interdepartmental Committee need not be given the power to disapprove federal grants, state replacement funds would not be available for programs which have not been certified by the Interdepartmental Committee as complying with the state plan.

The Interdepartmental Committee should also be designated as the central receiving bank for all information concerning drugs and alcohol. Each department or facility conducting a drug and alcohol program approved by the Interdepartmental Committee should make an annual report to the committee. These reports should contain such data as patients served, per patient cost figures, staff-patient ratios, and other relevant data requested by the coordinating agency. The Interdepartmental Committee should be responsible for evaluating this data.

The Committee believes that the Division of Alcoholism and Drug Dependence should continue to provide staff services to the Interdepartmental Committee. The Division is already conducting studies in the area of drugs and alcohol and collecting data in these areas. The Division is also giving assistance to local communities in establishing and locating funds for drug and alcohol programs.

Small Scale Treatment Facilities

Small-scale drug and alcohol treatment facilities such as Cenikor Foundation (Denver) have achieved some success in working with addicts who are willing to remain in the facility for a one-year period. Apparently, former drug users are sensitive to the problems of the addict and are better able to establish communication than professionals in traditional treatment modalities. Since the services provided are not professional, and the emphasis is on a personal and individual basis, the cost of these facilities is far below the more expensive state institutional programs. The Committee supports state funding of these small treatment facilities. The advantage of this kind of approach to treatment is twofold; small facilities offer an effective and low cost operation. For example, Bridge House in Grand Junction, has a successful rehabilitation program for alcoholics that operates for $5.00 a patient day. Finally, there are a number of facilities already in existence which could serve more people if additional funds were available. Currently, there are about 12 facilities, including those operated by the Salvation Army, that might be eligible for a program of state financial assistance.

Accreditation of Small Treatment Facilities. The proposed Interdepartmental Committee could be authorized to accredit and approve small treatment facilities as part of the state plan. In

developing standards for these facilities, the Committee believes that the programs should be allowed to remain as autonomous and independent as possible. The Committee recognizes that the effectiveness of these kinds of facilities lies in their freedom from interference from outside agencies and from strict conformity to specified rules and regulations. In essence, flexibility in the operation of facilities is essential. However, this does not mean that autonomy negates accountability. The agency which accredits such facilities must approve objectives and programs. Of course, all such programs would be subject to audit. In conclusion, any state standards should be flexible enough to allow each program to retain its unique character of treatment and approach.

The Committee also recommends that treatment facilities be encouraged to use former alcoholics and addicts as part of their staff. Whenever possible, treatment facilities could be assisted in establishing resident training programs to supply trained persons for the operation of similar programs elsewhere.

The Committee recommends that each small-scale facility operate on its own means for one year prior to making application for state moneys. The trial period will enable the state to more correctly estimate cost, evaluate program, and determine the effectiveness of the facility. In this way the state has some prior information on which to base its decision for accreditation and subsequent approval for funding.

The Committee suggests that annual statistics and financial records of all such facilities should be collected for analysis in a central data bank of the state coordinating agency. A central receiving place for information on these facilities would expedite comparisons and cost-benefit analysis of the facilities.

Finally, the Committee recommends that as a condition for approval for state funds, the program must be willing to serve any person who can benefit from the treatment program without regard to geographic residence, ethnic membership or ability to pay. Selection by any other factor than needs of the individual would defeat the purpose and intent of the state involvement in small treatment facilities.

Funding of Small Treatment Facilities. The Committee recommends that the state or local agency authorized to allocate funds should make a sum of money available to each facility based on the estimated number of persons to be treated. The grant would be made quarterly and depend on per patient costs of the facility subject to approval by the state agency. At the end of the quarter, or after a specified number of months, if the facility failed to meet its anticipated patient load, the money would revert back to the state agency. Monies could be reallocated to facilities that have exceeded their anticipated patient load.

State Appropriation for Drug and Alcohol Programs

The Committee recommends that the state funds to finance drug and alcohol programs be appropriated directly from the General Fund. The Committee recognizes that there is increasing competition for General Fund revenues, and it may be necessary to find additional sources of revenue to support the new drug and alcohol programs. Therefore, if the General Assembly, after reviewing this year's budget requests for drug and alcohol programs, determines that there are not adequate monies in the General Fund to support these programs, the Committee believes that legislation could be introduced in the 1971 Session to provide increases in tax rates on alcoholic beverages. The Committee believes that part of the revenue raised from these tax rate increases could help to offset the costs of the newly established drug and alcohol programs.

Consent of Minor for Drug Treatment

The Committee also recommends that legislation be adopted to allow a minor to seek medical treatment and continued care for the abuse of drugs, without the consent or notification of the parent. Many adolescents need and are willing to seek treatment for drug abuse but are unwilling to do so because their parents will be notified. There should be some way to allow a young addict or drug abuser to obtain the help he needs. The Committee recommends the adoption of legislation containing language similar to the existing law pertaining to treatment of minors for venereal disease.

Section 66-9-2, C.R.S. 1963 (1967 Supp.), states:

> (4) Any physician, upon consultation by a minor as a patient, with the consent of such minor patient, may make a diagnostic examination for venereal disease, and may prescribe for and treat such minor patient for venereal disease, all without the consent of or notification of the parent, parents, or guardian of such minor patient, or to any other person having custody of such minor patient. In any such case the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions.

Under present law, many physicians are reluctant to treat young drug users because they may become subject to suit. The proposed language would free physicians from liability for treating young drug users.

Recommendations Relating to Law Enforcement

Extension of Wiretapping Law to Include Dangerous Drugs. Colorado law, Section 40-4-30, C.R.S. 1963 (1969 Supp.), currently allows wiretapping to be used in cases involving violations of the state narcotics law as defined in Section 48-5-20, C.R.S. 1963. However, this device cannot be used in uncovering evidence concerning violations of the dangerous drug law. Law enforcement officers have testified that there is widespread abuse of the dangerous drug law and have requested that the Colorado wiretapping law be amended to allow them to use wiretapping to include offenses in the dangerous drug law.

The Committee recommends that Section 40-4-30, C.R.S. 1963 (1969 Supp.), be amended to allow wiretapping to include violations concerning the illegal manufacture, dispensing, possession, and use of dangerous drugs as provided in Section 48-8-2, C.R.S. 1963 (1969 Supp.). Since the federal law, Title 188 § 2516, United States Code Annotated, provides that offenses for which wiretapping can be used must be punishable by imprisonment for more than one year, the Committee further recommends that the penalty for the first conviction of possession and use of a dangerous drug as provided in 48-8-10 (6) (b), C.R.S. 1963 (1969 Supp.) be increased to up to 13 months.

Amendment of the Children's Code. The Committee recommends that the Colorado Children's Code be amended to allow transfer of information on youth under 18 from one law enforcement agency to another. Currently the Children's Code prohibits law enforcement agencies from sharing information on anyone under 18. While youthful narcotics or dangerous drug offenders (which constitute 70 to 80 percent of drug cases) might be active in different parts of the state, police agencies are still not allowed to share this information. The Committee recommends that the law be changed to allow the exchange of information just between police agencies but not for release to the news media, etc. This kind of information would greatly assist the police particularly in drug cases.

State Narcotics Unit. The Committee recommends the formation of a narcotics unit in the CBI to provide intelligence services to local authorities. The unit could provide manpower, facilities and equipment, especially to small counties and communities unable to combat local drug problems. Cooperation with the local authorities and the narcotics unit would be necessary. Local authorities could request the narcotics unit's assistance or if the narcotics unit had information about activities in a specific area, the local authorities would be notified.

Use of Tape Recorders in Obtaining Search Warrants. The Committee recommends that there be a statutory provision authorizing the use of tape recorders as an alternative to a written application for a search warrant. The Committee believes that the use of tape recorders would expedite obtaining search warrants. The current process for obtaining a search warrant is time-consuming and oftentimes the evidence and suspects disappear by the time a warrant is issued. The use of a tape recorder could be employed as follows: An officer requesting a search warrant would present his reasons to the proper judge, over the phone, and this conversation could be tape-recorded and later typed out. This procedure would allow the police officer to be en route to the judge to pick up the warrant. In this manner valuable time would be saved. Finally, the Committee believes that this procedure would meet the conditions imposed by Article II, Section 7, of the state constitution. This section requires: "...no warrant to search any place or seize any person or thing shall issue without describing the place to be searched, or the person or thing to be seized, as near as may be, nor without probable cause, supported by oath or affirmation reduced to writing."

The purpose of the requirement of writing appears to be first to supply a statement of probable cause to the judge who must issue a warrant and, secondly, to provide a permanent record of justification in the event that the warrant should later be contested in court. The Committee believes that these purposes can be achieved equally well by the use of a tape-recording, if proper protective measures are provided by statute. Such a statute would, of course, have to include provisions for the proper retention and preservation of whatever record is made of the oath of affirmation of probable cause.

Deferred Prosecution in Cases Involving Possession and Use of Narcotics. The Committee recommends that a section be added to the penalties and violations section for possession and use of narcotics to allow district attorneys to exercise a discretionary power of deferred prosecution in certain cases of possession and use of narcotics. There is a provision in the Colorado Dangerous Drug Act which provides for deferred prosecution on the first conviction of illegal possession and use of dangerous drugs. Perhaps a similar procedure could be included in the penalty section of the Narcotic Drugs Act which deals with possession (48-5-20 (2) (b)) and use (48-5-20 (5)).

COMMUNITY MENTAL HEALTH PROGRAMS

Community mental health is an umbrella-like concept developed in response to a need to interlock and expand the facilities available to people within a specific geographic area. Prior to the introduction of this concept, most mental patients had only two alternatives: care in a mental institution or private therapy. Very few facilities were available between these two extremes. Thus the community program, located close to where patients live, made available a comprehensive array of services with a "continuum of care". Under this program, patients remain close to their families and communities while undergoing treatment. The emphasis in treatment is the day hospital and outpatient clinic, not the 24-hour facility seen in an institutional program.

Summary of Federal Legislation

A series of comprehensive studies by the federal government were authorized by the National Mental Health Study Act of 1955. This act initiated a Joint Commission on Mental Illness and Health which, for a five year period beginning in 1956, examined the total spectrum of mental health needs. In early 1961, the commission's report was transmitted to Congress.1/ That same year President Kennedy appointed a committee to undertake an analysis of the commission's report.2/ This committee reported in December, 1962 and two months later the President sent to Congress proposals which in October, 1963, in reduced form, came to be known as the Community Mental Health Centers Act of 1963, Public Law 88-164.

In addition to the Centers Act, both the 1963 and 1964 appropriations for the National Institute of Mental Health carried an earmarked item of $4.2 million for grants to the states for comprehensive mental health planning. Thus, by the time the comprehensive centers act was implemented in 1965, a planning effort was established in most of the states, including Colorado.

1/ This report emphasized the need to upgrade the country's state mental hospital system to a therapeutic level. It suggested a cut in the maximum number of beds to 1,000 and the supplementing of the hospital's services by small outpatient clinics.

2/ This nonmedical, nonpsychiatric group reviewed the Joint Commission's Report and emerged with a new approach, the community mental health center.

P.L. 88-164, The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963

By providing grants to public institutions and nonprofit organizations for construction and initial staffing, Public Law 88-164, provided the major impetus for the development of community mental health and mental retardation facilities. Resembling the long standing Hill-Burton medical facilities construction legislation, this 1963 Act authorized appropriation of $150 million over a period of three years to assist in financing the construction of comprehensive community mental health centers. These federal funds must be matched by state and local moneys. In addition, the act set a variety of other requisites for state participation in the program: minimum service requirements from centers, a state plan, a state advisory council, and a survey of needs and ranking of geographic areas according to the severity of need. The act provided that the federal government would fund from one-third to two-thirds of the costs of construction of comprehensive community mental health centers. Construction monies were made available until 1973.

Each center is expected to serve a geographic area of no less than 75,000 people nor more than 200,000. In a rural region, small localities or counties in one or adjacent states may join together to form a center and share its facilities.

The act requires that each state draw up a state plan for the construction of centers based on a state-wide inventory of existing facilities. The Colorado State Plan is formally submitted by the administrator of the plan, the state Department of Health, although, by law, the state plan is formulated by the Department of Institutions, the state mental health authority.3/

The 1969 Colorado State Plan for Construction of Community Mental Health Centers is a 140 page publication detailing present and proposed facilities and treatment programs in the state's fifteen regions for mental health planning.4/

3/ The Colorado Department of Health administers the 1963 Act construction funds as provided by Sec. 66-18-3, C.R.S. 1963 (1965 Supp.).

4/ Likewise, the 1969 Colorado State Plan for Construction of Mental Retardation Facilities, a 90 page publication, details the present and proposed retardation facilities for the same geographic regions used for mental health planning.

To qualify for federal funds under the center's program, a mental health facility must provide at least five essential services:

1. Inpatient care;
2. Outpatient care;
3. Partial hospitalization;
4. Emergency care;
5. Consultation and education to community agencies and to professional personnel.

Regulations specify that services must be coordinated so that patients eligible in one treatment element will be eligible in any other and may be transferred among the services as a patient's condition requires. An applicant need not provide all five services himself, nor do the five need to be provided within the same or adjoining facilities. The concept of the community mental health center emphasizes a "continuum of care" for patients. Thus an applicant for assistance moneys may wish to sponsor only one of the five elements of service. The applicant is eligible for assistance providing the service will be part of a "continuum of care" in which all five essential elements, or more, are available and in which patients, clinical information, and mental health professionals can move without difficulty from one element of service to any other element, according to the needs of the patients. Thus the community mental health center concept refers more to patterns of care than to the facilities which deliver the care.

The Five Essential Services

Inpatient Services. This element offers treatment to patients who need 24-hour hospitalization. Frequently, the service is provided in a local general hospital affiliated with a center program. Among the features of an inpatient service are: an active treatment program including psychotherapy, chemotherapy, shock therapy, recreational therapy, occupational therapy, and medical treatment.

Those individuals in need of 24-hour care include the suicidal person; the acute schizophrenic who requires close supervision; the chronic schizophrenic; the person who is endangering his own or the welfare of others; the elderly patient who is extremely confused; and the child who has committed anti-social acts.

Inpatient care is the most expensive service in a center since it uses facilities and staff 24-hours a day. Costs vary from about $20 to $50 a day. A large percent of patients who receive intensive care respond within several weeks. After inpatient treatment, the patient may be transferred to another service such as partial hospitalization or outpatient care for continued treatment.

Outpatient Services. This is the largest of the center's services. Serving children as well as adults, the outpatient services of a center may also include programs for adolescents, the elderly, alcoholics, and drug addicts. The concept seeks to help people function at home and go about their daily activities. The usual kinds of treatment in the outpatient service are individual and group psychotherapy, drug therapy, psychodrama, and children's play therapy.

Partial Hospitalization. The National Institute of Mental Health has defined partial hospitalization in the following manner:

> A psychiatric day-night service is one having an organized staff whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities. The service is designed for patients with mental or emotional disorders who spend only part of a 24-hour period in the program. A psychiatrist is present on a regularly scheduled basis, and assumes medical responsibility for all patients. Or the psychiatrist may act as consultant to the staff on a regular basis. Under the latter arrangement, at least one of the following then assumes professional responsibility for the program: a physician, a psychologist, a psychiatric nurse, or a social worker.5/

Part-time hospital care may be provided in any one of a number of facilities. In some centers, care may be provided at the local hospital; in others, the service shares a building housing the outpatient service; and in others, all services including partial hospitalization are located in one building. Because the program does not include the need for 24-hour service, it eliminates the expense of 24-hour staffing. It has been estimated that the per diem cost to day patients is about one-third the cost of full hospitalization.

Emergency Services. This element offers emergency psychiatric service at any hour in one of the three units mentioned above -- inpatient, outpatient or partial hospitalization facilities. The requirements of an emergency program are: 24-hour walk-in service; 24-hour telephone service; home visits; and a service for suicide prevention. Walk-in services can be provided through regular emergency rooms at a general hospital, where psychiatric personnel are assigned and professionals are available on call. Home visits can be effective since a trained observer can quickly secure information about the patient and his family in their usual environment.

5/ Essential Services of the Community Mental Health Center, U.S. Department of Health, Education and Welfare, p. 2.

Consultation and Education. This element serves to relay mental health knowledge and therapeutic help to people in need through community professionals such as teachers, clergymen, policemen, physicians, social workers and public health nurses. Most community mental health centers allocate from five to twenty percent of their staff time to consultation.

Additional Services. A center may offer the following services in addition to the basic five for a comprehensive program:

> Diagnostic Services provide diagnostic evaluation and may include recommendations for appropriate care.
>
> Rehabilitative Services include both social and vocational rehabilitation. For example: vocational testing, guidance, counseling or job placement.
>
> Precare and Aftercare provides screening of patients prior to hospital admission, home visiting before and after hospitalization, and may make available followup services for patients at outpatient clinics, in partial hospitalization programs, in foster homes, nursing homes, or halfway houses.
>
> Training programs may be provided for all types of mental health personnel who serve the center's patients.
>
> Research and Evaluation may be undertaken by the center to evaluate the effectiveness of its program and to analyze the needs of the area it serves.
>
> Special Services may be offered for children, elderly citizens, alcoholics, or the retarded. Special services may also help to solve community problems such as drug abuse, suicide, or juvenile delinquency. If treatment of these groups or for these specific problems is not provided as a special service, it must be provided through the regular services of the center.

State Health Facilities Advisory Council

This eighteen member council was originally a nine member advisory hospital council formed to consult with the State Health Department in the administration of the federal Hill-Burton hospital funds. Its scope has been enlarged over the years to in-

clude consulting on carrying out the purposes of Public Law 88-164.6/ Members are appointed by the Governor for three year terms and represent organizations, groups and consumers concerned with mental retardation facilities, community mental health centers, and hospital and medical facilities projects under the federal Hill-Harris Act.7/

When potential applications for the construction of new mental health (or mental retardation) community facilities come to the attention of either the Department of Institutions or Department of Health, the staff of the other institution is kept informed. When the completed application is submitted to the Department of Health, a copy is sent to the Department of Institutions where a position statement is prepared containing the department's basic recommendations to the Advisory Council. Once the Advisory Council develops its recommendations, they are submitted to the State Board of Health for final action. If this board decides the application has merit, it is forwarded to the National Institute of Mental Health for final disposition.

P.L. 89-105, The Community Mental Health Centers Construction Act Amendments of 1965

Congress amended the 1963 centers act in 1965 to include assistance for the initial costs of personnel for mental health services established in addition to the already existing programs. Thus only personnel costs of a "new service" became eligible for a federal support grant. A total of $73.5 million was authorized for grants for the fiscal years 1966-68. In addition, continuation grants were made available over six fiscal years, 1967-72. Grants were available to cover staffing costs on a declining percentage basis for the first 51 months of operation of a new program. Grants were awarded for as much as 75 percent of eligible staff costs in the first 15 months of operation of a facility, 60 percent in the first subsequent year, 45 percent in the second subsequent year, and 30 percent in the final year. Eligible services were the five essential elements considered for a minimum comprehensive community program plus those five additional elements that make a facility a comprehensive program. For example, a "new service" could be consultation and education where none existed before but where the other four essential services already existed, or came into existence at the time the consultation and education element did. Or a precare service could be added to an already existing service comprising the five needed services. The definition of a "new service" could be widened to

6/ This designation is made in Sec. 66-18-3, C.R.S. 1963 (1965 Supp.)

7/ Sec. 66-18-2, C.R.S. 1963 (1965 Supp.) spells out the functions of the Council.

include: extension of service to a new geographical area, although service may have been available to residents of other parts of the total service area; or a special service to a particular group such as adolescents; or a new method of delivering a service, not used in the community before, even if there has been a related type of service.

Many Colorado community facilities received P.L. 89-105 moneys.

P.L. 91-211, Community Mental Health Centers Act Amendments of 1970

Under the 1970 amendments to the Community Mental Health Centers Act of 1963, funding for construction of centers was extended until 1973 with a maximum of 66 2/3 percent of federal funding, or the state's federal percentage, whichever is less, to cover the costs of construction. (The state's federal percentage is based on the relationship of the state's per capita income to the per capita income of the United States. Colorado's federal percentage for 1969 was 47.875 percent. This percentage is the statewide average federal share.) After June 1, 1970, the federal grants for staffing (compensating not only professional and technical personnel 8/ but also operating costs) will be extended for eight years with the federal percentage of moneys beginning at 75 percent for the first two years, 60 percent for the third year, 45 percent for the fourth year, and 30 percent for the last four years.

8/ Under P.L. 91-211, section 265:

> For purposes of this title, the term "technical personnel" includes accountants, financial counselors, medical transcribers, allied health professions personnel, dietary and culinary personnel, and any other personnel whose background and education would indicate that they are to perform technical functions in the operation of centers or facilities for which assistance is provided under this title; but such term does not include minor clerical personnel or maintenance or housekeeping personnel.

In addition to the regular staffing grant another grant, for compensation of technical and professional personnel who provide consultative services, may be obtained. The new federal law also provides that the states may use 5 percent (up to a maximum of $50,000) of their allotment for construction grants for the administration of their state plan. This money is available for a two year period.

Rural or Urban Poverty Area

The 1970 amendments to the Community Mental Health Centers Act make special provisions for rural or urban poverty areas with respect to construction, staffing, and initiation of services grants. A rural or urban poverty area is defined as follows:

> For purposes of any determination by the Secretary under this Act as to whether any urban or rural area is a poverty area, any such area which would not otherwise be determined to be a poverty area shall, nevertheless, be deemed to be a poverty area if --
>
> (1) such area contains one or more subareas which are characterized as subareas of poverty;
>
> (2) the population of such subarea or subareas constitutes a significant portion of the population of such rural or urban area; and
>
> (3) the project, facility, or activity, in connection with which such determination is made, does, or (when completed or put into operation) will, serve the needs of the residents of such subarea or subareas.9/

Under P.L. 91-211 any grant for construction, whether it be a community mental health center, alcoholic or narcotic addict treatment facility, or a facility which provides mental health services to children, in an area designated as a rural or urban poverty area can be federally funded up to 90 percent of the costs of such construction. Under the new federal law all construction grants have been extended for three years until June 30, 1973.

9/ P.L. 91-211, Title V Miscellaneous, Section 504.

The schedule of federal share of staffing grants in an area designated as a rural or urban poverty area is as follows:

90% of the costs for the first two years
80% of the costs for the third year
75% of the costs for the fourth and fifth years.
70% of the costs for the last three years.

Staffing grants are made for the duration of eight years.

Up to $50,000 can be granted for one year to local public or nonprofit organizations to cover 100 per centum of the costs of projects in areas designated as rural or urban poverty areas for "assessing local needs for mental health services, designing mental health service programs, obtaining local financial and professional assistance and support for community health services, and fostering community involvement in initiating and developing community mental health services." 10/

The new federal law also provides that the requirement of the five essential services to initiate a community mental health center need not be met by such a facility beginning services in an area designated as a rural or urban poverty area. However, a facility in a rural or urban poverty area is given eighteen months in which to establish the five essential services. Failure of the center in an urban or rural poverty area to do so at the end of the eighteen months will result in suspension of any grant made under these conditions.

Alcoholism and Narcotic Addicts

In 1968 the provisions of the Alcoholic Rehabilitation Act and Narcotic Rehabilitation Act (P.L. 90-574) were added to the Community Mental Health Centers Act (P.L. 88-164). Construction grants for both alcohol and narcotic addicts facilities were authorized on the same matching basis as grants to community mental health centers -- up to two-thirds the cost of the projects cost. Staffing grants were also authorized on the same matching basis as grants to community mental health centers -- seventy-five percent of the initial cost declining to 30 percent of the cost over a period of 51 months.

The basis of the alcohol and narcotic addict programs is that these programs be community oriented with a range of comprehensive services. Since 1968, apparently, the state has not

10/ P.L. 91-211, Title II - Programs of Grant Assistance for Community Mental Health Service, Section 202.

made use of these moneys. In 1970 P.L. 91-211 amended the original Community Mental Health Centers Act with emphasis on the development of alcoholic and narcotic addict treatment facilities. The intent of this emphasis can be found in a summation of the conference committee's policy with regards to alcoholism and drug addiction which follows:

> Alcoholism and drug abuse are fields which have long been neglected by the medical profession. The alcoholic, or the drug abuser, is frequently an extremely difficult patient to deal with, and mental health professionals in general have shown considerably less interest in the problems of these patients than they have in the problems of other patients who are easier to treat. For this reason, the conferees direct that the National Institute of Mental Health take all appropriate steps to direct more attention to problems of alcoholism and drug abuse, and aggressively pursue programs designed to stimulate the interest of professionals in these fields. 11/

Under the new law programs for federal assistance of alcoholic and narcotic addict treatment facilities are extended to three years. Grants up to $50,000 can be made for one year to local public or nonprofit private organizations to cover 100 percent of the costs of projects for "assessing local needs for programs of services for alcoholics or narcotic addicts, designing such programs, obtaining local financial and professional assistance and support for such programs in the community, and fostering community involvement in initiating and developing such programs in the community." 12/

The new federal law extends until 1973 grants for construction of alcoholic and narcotic addict treatment facilities. The maximum federal share of the costs of construction cannot exceed 66 2/3 percent or 90 percent of the costs if the facility provides services to an area designated as an urban or rural poverty area. The new staffing grant provisions for alcoholic treatment and prevention facilities, or specialized facility for alcoholics, or a treatment facility for narcotic addicts, are of eight years duration and with the following federal percentages:

11/ U.S. Code Congressional and Administrative News, Conference Report No. 91-856, p. 369.

12/ P.L. 91-211, Title III - Alcoholism and Narcotic Addict Rehabilitation, Section 301.

80% of the costs for the first two years
75% of the costs for the third year
60% of the costs for the fourth year
45% of the costs for the fifth year
30% of the costs for the remaining three years

Under the new federal law direct grants for special projects in the fields of alcoholism and narcotic addicts are extended for a three year period ending June 30, 1973. These grants may cover all or part of the costs of the following:

> (1) developing specialized training programs or materials relating to the provision of public health services for the prevention or treatment of alcoholism, or developing inservice training or short-term or refresher courses with respect to the provision of such services; (2) training personnel to operate, supervise, and administer such services; (3) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs; and (4) programs for treatment and rehabilitation of alcoholics which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such alcoholics.
>
> and (D) programs for treatment and rehabilitation of narcotic addicts which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such narcotic addicts. 13/

Mental Health Services for Children

A new section was added to P.L. 91-211 (amendments to the Community Mental Health Centers Act) to include grant assistance for facilities to provide mental health services for children. Under this section a grant can only be made to a facility affil-

13/ P.L. 91-211, Title III - Alcoholism and Narcotic Addict Rehabilitation, Section 246 and Section 305.

iated with a community mental health center with the following exception: if no community mental health center exists, a grant for a facility to provide mental health services can be made if the facility applying for the grant has made provisions for appropriate utilization of existing community resources. "In addition, an applicant for a grant must assure that a full range of treatment, liaison, and follow up services and, if requested, consultation and education services would be provided." 14/

Construction grants are authorized for three years from 1970 through 1973 and the federal share of the costs of construction cannot exceed 66 2/3 percent. Staffing grants are provided for eight years duration with the following schedule of federal assistance:

80% of the costs for the first two years
75% of the costs for the third year
60% of the costs for the fourth year
45% of the costs for the fifth year
30% of the costs for the remaining three years

If such a facility serves an area designated as an urban or rural poverty area the schedule of federal assistance is the same as the schedule included in the section on poverty.

In addition, grants for training and evaluation are available for three years, 1970 through 1973 to pay for all or part of the costs of

> (1) developing specialized training programs or materials relating to the provision of services for the mental health of children, or developing inservice training or short-term or refresher courses with respect to the provisions of such services; (2) training personnel to operate, supervise, and administer such services; and conducting surveys and field trials to evaluate the adequacy of the programs for the mental health of children within the several states with a view to determining ways and means of improving, extending, and expanding such programs. 15/

14/ U.S. Code Congressional and Administrative News, Conference Report No. 91-856, page 371.
15/ P.L. 91-211, Title IV - Mental Health of Children, Section 272, page 8.

Intent of the Amendments as Outlined in the Conference Report

With regards to P.L. 91-211, the 1970 amendments to the Community Mental Health Centers Act, a number of basic changes in the intent of the law were expressed by the conferees. The following statements were taken from Conference Report No. 91-856, as found in the U.S. Code Congressional and Administrative News, P.L. 91-197 to 91-214, 1970, pages 364-372.

Staffing grants

1) Since some grants made under the old law will extend past 1970, the conference committee inserted language, in each section of the new law which mentions staffing grants, to allow for the old staffing grants. As the council staff interprets these amendments, for those staffing grants made prior to July 1, 1970 (under the Community Mental Health Centers Act, as amended, 1967), the new percentages of the federal share of staffing grants will, with respect to costs incurred after June 30, 1970, apply to that grant as if such new percentages had been in effect on the date the staffing grant was initially made. In other words, if a staffing grant was approved in June, 1968, under the old staffing grant it would be in its third year of duration and be receiving the federal percentage of 45 percent. Under the 1970 amendments such grant made in June, 1968, would also be in its third year of duration but with a federal percentage of 60 percent. The grant's duration would be extended for eight years, counting 1968 as the grant's first year.

2) The conference committee also noted with respect to staffing grants:

> Although there are special provisions in this legislation for facilities serving the needs of alcoholics, narcotic addicts, and the mental health of children, it should be emphasized that every community mental health center may use grant assistance under this section for such programs in order to provide assistance to persons suffering from any mental or emotional disability, particularly adolescent narcotic addicts or drug abusers.

3) A center must meet certain criteria in order to qualify for a federal staffing grant. It was the conference committee's intent with regards to assurances of the services to be provided in approving such a grant that:

> . . . grant could be made with respect to a community mental health center only if the Secretary (HEW) determined that the

services to be provided would be in addition to, or a significant improvement in, the services that would otherwise be provided.

4) One of the conditions precedent to approval of a staffing grant is that the federal funds which are made available be used to supplement and not to supplant state, local and other non-federal funds, including third party health insurance payments.

Grants for Initiation and Development of Services

It is the intention of the conferees that grants under this section, as well as grants for initiation and development of programs of services for alcoholics and narcotic addicts shall be made to persons who are qualified, and who are knowledgeable of the health needs of the population to be served by the project.

Approval of Grants

The conference committee provided that grants for construction and for the cost of compensation of professional and technical personnel under the Community Mental Health Centers Act may be made only upon recommendation of the National Advisory Mental Health Council. The conference committee concluded its report with the following statement.

In the hearings before both the House and Senate committees it became apparent that there are a wide variety of types of community mental health centers throughout the United States ranging from those serving very large geographic areas with sparse population to those serving extremely densely populated areas in our cities. The types of services provided by these facilities vary widely, and a great deal of experience has been gained over the last few years by these various centers.

The conferees feel that the National Institute of Mental Health should therefore select a number of centers that demonstrate various approaches to service, and that serve different types of populations, in order to study extensively the variables, problems, and effectiveness of their programs.

With respect to site visits, the conferees feel that future site visit teams should include at least one representative from a mental health center not from the same region as the site being visited, that at least one center representative sit on Grant Review Committee at the regional level, and that two center directors serve on the National Review Committee.

Summary of the Significant Aspects of the Community Mental Health Centers Amendments of 1970

The Community Mental Health Centers Amendments of 1970 extends the construction grants for three years and staffing grants for eight years. As a result of the amendments, staffing grants include operating costs and have higher percentages of federal monies assigned to them for the various years of their duration. Special provisions are made for facilities and services for alcoholics, narcotic addicts and the mental health of children. In addition, greater federal percentages are allowed for the construction and maintenance of mental health facilities in poverty areas. The intent of the conference committee, which formulated the final legislation, was that the extension of increased federal support to the community mental health centers program was to expedite the establishment of centers and to improve their services.

Other Federal Funds

314(d) Grants. The Public Health Service Act provides that at least 15 percent of the federal monies allotted to the state for comprehensive public health services shall be allotted to the state mental health authority for state and local mental health services. The state mental health authority in Colorado is the Department of Institutions. The department can use up to 30 percent of the allotted monies for administration and the remaining 70 percent must go to mental health agencies in local political subdivisions. Not only centers and clinics are eligible to receive these funds, but also other agencies and organizations which provide local mental health services.

Table I on pages 39 and 40 shows the actual amount of 314(d) monies distributed to the various clinics and centers in 1969-70. The actual amounts other agencies received in fiscal 1970 is shown below. The total actual amount of 314(d) monies spent in fiscal 1970 was $81,092.

	Recipient Agency	Federal 314-D
1)	Denver Visiting Nurses Association	4,000
2)	Jefferson County Health Department	2,500
3)	San Juan Basin Health Department	2,188
4)	Southern Colorado State College	2,105
5)	Tri-County District Health Department	2,225
6)	University of Colorado - Department of Psychology	1,400
7)	Lynwood M. Hopple, M.D. (for Southeastern Colorado)	5,400
		19,818

Colorado's Community Mental Health Facilities Listed By Region

As required by the 1963 federal legislation, the state is divided into mental health service areas or regions. Colorado is divided into fifteen such regions on the basis of demographic and topographic characteristics of the state. At present, under the coordination of the Department of Institutions, there exist twenty-two mental health facilities. In addition to the twenty-two facilities there are a variety of other public and private functions in the various regions providing mental health services.

Colorado Revised Statutes 1963, (1967 Supp.) § 3-11-16 provides the following statutory definitions of a community mental health clinic and a community mental health center:

> (2) "Community mental health clinic" means a health institution planned, organized, operated, and maintained to provide basic community services for the prevention, diagnosis, and treatment of emotional or mental disorders, such services being rendered primarily on an outpatient and consultative basis.
>
> (3) (a) "Community mental health center" means either a physical plant or a group of services under unified administration or affiliated with one another, and including at least the following services provided for the prevention and treatment of mental illness in persons residing in a particular community or communities in or near the facility so situated:
>
> (b) Inpatient services;
> (c) Outpatient services;
> (d) Partial hospitalization;
> (e) Emergency services;
> (f) Consultative and educational services.

At present Colorado has six community mental health centers[16] and sixteen community mental health clinics.[17] The following is a brief description of mental health facilities by region. A major part of the information on the fifteen mental health planning regions has been extracted from the 1969 State Plan for Construction of Community Mental Health Centers. The plan is formulated by the Department of Institutions in compliance with the Centers Act of 1963. The statistical information was supplied by the Department of Institutions.

Region 1

Region 1 is served by four mental health care facilities: Midwestern Colorado Mental Health Center at Montrose, Mesa County Mental Health Clinic at Grand Junction, Sopris Mental Health Clinic at Glenwood Springs, and Northwest Colorado Mental Health Service at Hayden. Because of the massive land area encompassed by Region 1 it is divided into four sub-regions.[18]

Sub-region 1-A is offered the services of the Midwestern Colorado Mental Health Center which provides the five essential elements of a center: inpatient and outpatient care, emergency service, partial hospitalization, consultation and education service. In addition, the center has an after-care program for ex-hospital patients, and a staff training program. In fiscal year 1970, this center served a total of 387 patients at a total cost of $76,968. Other data which give a profile of 1970 fiscal year's operations include:

16/ Centers: Adams, Arapahoe, Denver General Hospital, Jefferson, Midwestern (Montrose), and Weld.

17/ Clinics: Boulder*, Denver Mental Health Center, Children's Hospital, Bethesda*, Larimer, Mesa, Northeast, Northwest, Pikes Peak, San Luis Valley, Sopris, Southeast, Southwest, Spanish Peaks**, West Central, East Central.

* Boulder and Bethesda Mental Health Centers qualify as centers by providing the five essential services, and have received federal staffing grants. However, the state has not yet provided funds for either Boulder or Bethesda as centers.

** Spanish Peaks Mental Health Clinic provides outpatient services for the Southern Colorado Mental Health Center. The inpatient services are provided at the State Hospital at Pueblo. No state funds have been used out of the state monies for the purchase of inpatient community mental health services as such funds have been included in the State Hospital budget.

18/ The four sub-regions of Region 1 are: sub-region 1-A, Delta, Montrose, Ouray, Hinsdale, Gunnison, and one-half of San Miguel counties; sub-region 1-B, Mesa county; sub-region 1-C, Garfield, Pitkin and Eagle counties; and sub-region 1-D, Moffat, Routt, Jackson and Grand counties.

Number of interviews	1,393
Number of hours spent in community services	10,923
State funds	$30,977
Federal funds	27,170
Local share	19,211
Included in Local share is "Fees"	2,628

The indirect services provided by the Midwestern Colorado Mental Health Center include a wide range of consultation services to the sheriff, the welfare department, and public health nurses. The services of a child psychiatry resident from the University of Colorado Medical Center were used in a consultative role. Funding for this consultation service came from the allotment of 314(d) federal monies in the amount of $3,720. This amount is part of the federal share listed above: $27,170.

Until May 1, 1969, the Gunnison-Hinsdale Guidance Service operated as an established mental health clinic, offering outpatient care, emergency service, diagnosis and observation, an after-care program for ex-hospital patients and training service. At that time it merged with the Midwestern Colorado Mental Health Clinic and this facility now serves all of sub-region 1-A.

Sub-region 1-B has one mental health clinic serving its area. The Mesa County Mental Health Clinic offers outpatient care, emergency service, partial hospitalization, diagnosis and observation, rehabilitative service, pre-admission service, an after-care program for ex-hospital patients and staff training. In fiscal year 1970, 487 patients were served by the clinic at a total cost of $60,419. Other data which give an outline of 1968 fiscal year operations include:

Total number of patients	487
Number of interviews	1,366
Hours in community service	886
Fees collected	$1,253
State share	$28,216
Federal share	$ 3,504
Local share	$28,699
Total cost	$60,419

It is to be noted that in this period the services of a child psychiatry resident were used for consultation to schools, nurses, and other care givers in the community. The decline in reported interviews is partially based on a breakdown in reporting because of a change in secretarial personnel.

Sopris Mental Health Clinic at Glenwood Springs serves sub-region 1-C. It is a part-time facility offering outpatient care, rehabilitative service, pre-admission service, and an after-care program for ex-hospital patients. At a total operating cost of $30,101, it served 146 patients in fiscal year 1970. Other data for fiscal year 1970 include:

Number of patients treated	146
Number of interviews conducted	744
Hours in community service	469
Local share	$17,037
State share	13,064
No Federal share	
Total cost for fiscal year 1970	$30,101

Sub-region 1-D has the Northwest Colorado Mental Health Service serving Routt and Moffat counties with outpatient care. Staff training is also provided. Some 123 patients were served by the clinic at a total cost of $34,382 during fiscal year 1970. Information outlining the 1970 fiscal year's operations includes:

Number of patients treated	123
Number of interviews	660
Hours in community service	1,321
Fees collected	$ 2,014
State share	6,688
Local share	23,947
Federal share (The Federal money was 314(d) money for the employment of a child psychiatry resident who gave consultation to care givers in welfare, schools, and ministers.)	3,747
Total cost	$34,382

The State Plan Recommendations. The 1969 State Plan recommended that a state operated, regional psychiatric hospital be located in Grand Junction to provide long-term care for patients from all of Region 1 and 24-hour care and partial hospitalization for Mesa County. The 1970 Legislature appropriated $24,000 for the services of an architect to plan for the construction of a hospital at Grand Junction. This is to provide for 35 beds, with a wide range of services.

Region 2

The Southwest Mental Health Center at Durango serves Region 2. This clinic offers only outpatient care and an after-care program for ex-hospital patients; long-term care is handled

by the state hospital at Pueblo. In fiscal year 1970, 309 patients were served by the clinic at a cost of $42,925. Other data outlining the 1970 fiscal year's operations include:

Total number of patients	309
Number of interviews	1,854
Hours in community service	264
Fees collected	$ 2,907
Local share	15,063
State share	19,620
Federal share	8,242
Total cost	$42,925

The private facility in the region is the Pinerock Ranch School. It provides residential treatment for children ages 5-15.

The State Plan Recommendations. The State Plan recommends that this region enter a joint comprehensive community mental health center project with the Farmington-Aztec area of New Mexico. For the time being, the report suggests that the local hospitals might be utilized for brief 24-hour or partial hospitalization.

Region 3

Larimer County constitutes Region 3 and is served by the Larimer County Mental Health Clinic in Fort Collins. This clinic offers outpatient care, emergency service, diagnosis and observation, an after-care program for ex-hospital patients and staff training. In fiscal year 1970, 676 patients were served at a total cost of $73,779. Other data giving a profile of 1970 fiscal year's operations include:

Total number of patients	676
Number of interviews	3,007
Hours in community service	812
Fees collected	$13,733
Local share	27,205
State share	43,106
Federal share	3,468
Total cost	$73,779

This clinic is already well established with the facilities of and services of the Colorado State Health Services and the Poudre Valley Hospital. The components of a comprehensive community mental health center now exist and it appears to be a matter of organization and funding to unify these factors into a center.

The existing mental health facilities in Fort Collins are augmented by Colorado State University which provides its students with mental health services through the Student Health Services.

Region 4

Region 4, Weld County, is served by two facilities. The Mental Health Center of Weld County offers the required five functions to qualify as a center: inpatient and outpatient care, day and night hospitalization, emergency service, diagnosis and observation, an after-care program for ex-hospital patients, and staff training. At a total cost of $272,115 the center served 1,285 patients in fiscal year 1970. Other 1970 statistics include:

Total number of patients	1,285
Number of interviews	5,536
Hours in community service	5,170
Fees collected	$38,074
Local share	38,705
State share	95,955
Federal share	137,381
Total cost	$272,115

A second facility in Region 4, the Weld County General Hospital, provides inpatient care, day and night hospitalization, emergency service, and diagnosis and observation.

The State Plan Recommendations. The 1969 State Plan recommends that a 60-bed, state-operated, psychiatric hospital be located in Greeley to serve a dual purpose: provide long-term care for patients from all of northwest Colorado and supplement facilities for the Mental Health Center of Weld County.

Region 5

The West Central Guidance Center at Canon City offers outpatient care, emergency service, diagnosis and observation, rehabilitative service, an after-care program for ex-hospital patients and research services to the populace of Region 5. At a total cost of $38,387 this clinic served 425 patients in fiscal year 1970. Other data which gives a profile of 1970's operations include:

Total number of patients	425
Number of interviews	1,802
Hours in community service	452

Fees collected	$ 2,031
Local share	15,659
State share	22,725
No Federal share	
Total cost	$38,387

1969 State Plan Recommendations. The 1969 State Plan notes that the proximity of the state hospital at Pueblo precludes the possibility of developments in this region in the near future and that the satellite clinics in Salida and Leadville might make use of local hospitals for acute cases.

Region 6

Region 6 has the services of a part-time clinic: the San Luis Valley Mental Health Clinic of Monte Vista. These services are limited to outpatient and pre-admission functions. In fiscal year 1970, 162 patients were served at a total cost of $34,130. Data for fiscal year 1970 includes:

Total number of patients	162
Number of interviews	782
Hours in community service	452
Fees collected	$ 1,708
Local share	11,975
State share	19,152
Federal share	3,003
Total cost	$34,130

1969 State Plan Recommendations. The State Plan recommendation notes:

> These six counties in the San Luis Valley comprise the most economically depressed area of the state. Many basic health services are unavailable to people...every effort must be made to coordinate planning for mental health services in this region with planning for overall health services... Either one of three hospitals located in Alamosa, Monte Vista or Del Norte could be adapted for short-term patient care. Traveling teams of the state hospital's Southern Division provide and should offer services to the people of this region on an expanding scale until such time that basic economic and health problems can be resolved.19/

19/ 1969 State Plan, p. 62.

Region 7

The Northeast Mental Health Clinic at Sterling serves Region 7 by providing inpatient and emergency services, training and research services. Branch services of the clinic are offered at Fort Morgan. In fiscal 1970, the clinic served 908 patients at a total operating cost of $102,174. Other data which gives a profile of 1970's operations include:

Total number of patients	908
Number of interviews	3,665
Hours in community service	2,038
Fees collected	$ 8,916
Local share	67,182
State share	32,029
Federal share	2,963
Total cost	$102,174

In addition to being the headquarters for the Northeast Colorado Health Department, Sterling has the largest general hospital, a county facility operated by Lutheran Hospitals and Homes Society.

1969 State Plan Recommendations. According to the State Plan Report, this region has one of the best established mental health clinics in any rural area of Colorado. With clinic headquarters at Sterling and a branch at Fort Morgan, there are elements of a center. This hospital could house a small inpatient unit as part of a comprehensive community mental health center.

Region 8

Region 8 is served by the Pikes Peak Family Counseling and Mental Health Center in Colorado Springs; this clinic offers outpatient service, day partial hospitalization, pre-admission service, an after-care program for ex-hospital patients and research services. At a total cost of $176,586 this clinic served 787 patients in fiscal year 1970. Other information on the Colorado Springs clinic includes:

Total number of patients	787
Number of interviews	4,255
Hours in community service	841
Fees collected	$20,938
Local share	70,634
State share	105,952
No Federal share	
Total cost	$176,586

Since fiscal year 1968, the East Central Colorado Mental Health Clinic has come into being. The Articles of Incorporation were written in March 1969 and services began in May of the same year. This clinic covers Lincoln, Kit Carson, and Cheyenne Counties. Because of its size and also because of its funding limitations, it is serviced by part-time staff whose main position is with the Northeast Colorado Mental Health Clinic. Data for 1970 fiscal year's operations are as follows:

Total number of patients	91
Number of interviews	475
Hours in community service	372
Fees collected	$ 1,000
Local share	2,870
State share	7,890
Federal share	1,495
Total cost	12,255

Other facilities providing mental health services in this area are Emory John Brady, the Brockhurst Boys Ranch, and the Family Counseling Service of Colorado Springs.

State Plan Recommendations. The 1969 Report suggests that the Pike's Peak Center is the logical core agency for a comprehensive community mental health center with the possibility of establishing an inpatient unit at the Colorado Springs Memorial Hospital. Since Colorado Springs is the heaviest center of population in this area, the Department also recommends that El Paso and Teller counties combine in one community mental health center project and that the three remaining counties, Kit Carson, Cheyene, and Lincoln, join in another. The East Central Colorado Mental Health Clinic covers these three counties.

Region 9

The Southeast Colorado Family Guidance Center at La Junta serves Region 9. This clinic has a facility at Las Animas as well as La Junta and offers outpatient and emergency service, diagnosis and observation, after-care program for ex-hospital patients, and research services and staff training. In fiscal 1970, 363 patients were served at a total operating cost of $72,855. A profile of 1970 operations includes:

Total number of patients	363
Number of interviews	2,072
Hours in community service	908
Fees collected	$ 3,405
Local share	36,070
State share	36,785
No Federal share	
Total cost	$72,855

Fort Lyon Veteran's Administration Hospital, located in this area, supplies supplemental facilities and services.

1969 State Plan Recommendations. The 1969 Report notes that a comprehensive center might be established in La Junta or Lamar, each of which have a general hospital where short-term, psychiatric, inpatient facilities might be established. The Report recommends the use of Fort Lyons as continued supplemental support for the proposed center.

Region 10

The Spanish Peaks Mental Health Clinic recently combined with Southern Division of the State Hospital in Pueblo to form the Southern Colorado Comprehensive Mental Health Center. This facility provides inpatient and outpatient service, emergency service, partial hospitalization and consultation and education. In addition, it provides staff training, and research services.

In fiscal year 1970 the center served 907 patients at a total cost of $239,800. Other data which gives a profile of 1970 fiscal year's operations include:

Total number of patients	907
Number of interviews	4,981
Hours in community service	2,858
Fees collected	$ 35,633
Local share	107,254
State share	76,912
Federal share	55,634
Total cost	$239,800

The Colorado State, St. Mary Corwin and the Parkview Episcopal Hospitals and the Family Service of Pueblo augment Region 10's mental health services.

Region 11

Region 11 is served by the Joseph S. Gollob Adams County Mental Health Center which offers the necessary services to qualify as a center: inpatient and outpatient service, day partial hospitalization, emergency service, and consultation and education. The center also has an after-care program for ex-hospital patients. At a total cost of $385,309 the center served 2,824 patients in fiscal 1970. Other data include:

Total number of patients	2,824
Number of interviews	11,234
Hours in community service	10,557

Fees collected	$ 27,569
Local Share	70,514
State share	148,342
Federal share	166,453
Total cost	$385,309

Region 12

The Arapahoe Mental Health Center offers the essential services of inpatient and outpatient care, day partial hospitalization, emergency service, and consultation and education. In addition, the center has an after-care program for ex-hospital patients.

The Arapahoe center, located in Englewood, has a complete branch office in Aurora, a sub-catchment area for this mental health region. The Arapahoe center contracts with the University of Colorado Psychiatric Hospital to provide inpatient service for those adolescents over 16. And, depending on the type of treatment, other patients from the Arapahoe catchment area are served. One emergency social worker who spends 20 percent of her time at the center and the other 80 percent at the Psychiatric Hospital works in evaluating patients for admission to the hospital. The partial hospitalization at the University hospital is only short-term.

In fiscal year 1970 the center served 1,112 patients at a total cost of $482,979. Other data which gives a profile of 1970 operations include:

Total number of patients	1,112
Number of interviews	16,052
Hours in community service	11,547
Fees collected	66,481
Local share	110,953
State share	113,632
Federal share	258,394
Total cost	$482,979

The Arapahoe team at Fort Logan contracts with the center to provide emergency hospitalization and inpatient care to the rest of the population of this region. The Family and Children's Service of Colorado (Englewood) offers family guidance service to this area.

1969 State Plan Recommendations. The branch clinic in Aurora is unique in that it serves both Adams and Arapahoe counties. At present it divides its services in conjunction with both the Arapahoe and Adams centers. The 1969 Report recommends establishing a full center in Aurora and eliminating the division of its services between Adams and Arapahoe counties.

Region 13

Region 13 is served by the Jefferson County Mental Health Center, a center which provides outpatient care, day partial hospitalization, emergency service, and consultation and education services. Also provided are an after-care program for ex-hospital patients and staff training. The center served 994 patients in fiscal year 1970 at a total cost of $314,804. A profile of fiscal 1970 also includes:

Total number of patients	994
Number of interviews	6,918
Hours in community service	2,111
Fees collected	$ 61,625
Local share	99,563
State share	134,650
Federal share	80,590
Total cost	314,804

In addition to the services listed above, the Jefferson Center offers a day care program for adults and a psycho-educational program for school children. In contract with Fort Logan, day care is provided by the Jefferson team at Fort Logan. This completes the five essential services needed by the Jefferson County center to qualify as a center. A center office located in Arvada has been expanding to provide outpatient consultation services closer to patients in the northern part of the Region's catchment area.

The Family and Children's Service of Colorado (Lakewood) and Forest Heights Lodge augment the area's services

Region 14

The Mental Health Center of Boulder County provides Region 14 with outpatient services, diagnosis and observation, consultation and education, rehabilitative care, pre-admission service, an after-care program for ex-hospital patients, and staff training. Because the facility does not provide the five essential services, the Boulder Center is a center in name only. In Fiscal 1970, 804 patients at a total cost of $158,266 were served by the clinic. A profile of the clinic's operations includes:

Total number of patients	804
Number of interviews	5,539
Hours in community service	1,522
Fees collected	$ 24,260
Local share	94,947
State share	58,729
Federal share	4,590
Total cost	$140,702

To supplement the clinic's efforts in Region 14, the Evergreen Girl's Ranch, the Family and Children's Service of Colorado and the University of Colorado's Wardenburg Health Center supply services.

Region 15

As the 1969 State Plan notes, "the City and County of Denver is by far the most heavily populated region with the most complex array of services in the state."20/ There are two community mental health centers and three clinics plus a variety of other mental health facilities available in the Denver Metropolitan area. The Department of Health has arbitrarily divided Denver into four catchment areas: northwest, northeast, southwest and southeast.

Bethesda Mental Health Center, which is affiliated with Bethesda Hospital, began its operations August 1, 1969. The facility offers the five essential services needed for designation as a center. It is staffed with one and a quarter psychologists, one psychiatrist, five social workers, and a director. In its first month of operation the center has admitted one inpatient and served ten outpatients. It is intended to serve the southeast catchment area of Denver. Data giving a profile of Bethesda Mental Health Center's operations includes:

Total number of patients	556
Number of interviews	3,691
Hours in community service	2,392
Fees collected	$ 31,282
Local share	189,894
State share	40,000
Federal share	227,153
Total cost	457,047

Denver General Hospital operates a community mental health center offering, in addition to the five essential services, diagnosis and observation, rehabilitative and pre-admission service, an after-care program for ex-hospital patients, and staff training and research services. At a total cost of $2,617,973 this facility served 8,804 patients in fiscal year 1970. An explanation of operation of the center in 1970 includes:

Total number of patients	8,804
Number of interviews	37,324
Hours in community service	9,833

20/ 1969 State Plan, p. 111.

Fees collected	Unknown
Local share	380,003
State share	207,512
Federal share	2,030,458
Total cost	2,617,973

Denver General Hospital serves primarily the northwest area of Denver.

The Denver Mental Health Center is a private non-profit clinic providing only inpatient care and an after-care program for ex-hospital patients. In fiscal year 1970 the clinic served 174 patients at a total cost of $98,294. Other data giving a profile of fiscal 1970 operations include:

Total number of patients	174
Number of interviews	6,182
Hours in community service	2,896
Fees collected	$ 48,479
Local share	51,101
State share	41,000
Federal share	6,193
Total cost	98,294

The Southwest Denver Mental Health Center is staffed by a team from Denver General Hopsital and Fort Logan Mental Health Center. Presently the clinic is not housed in an actual structure. Fort Logan's D-2 team provides inpatient and partial hospitalization; Denver General supplies outpatient and consultation service with their psychiatric Team 1; and emergency service is provided by both. A great percentage of the emergency cases are handled by Denver General as the police must take any emergency case there.

This clinic has been entirely reorganized in the last year. Currently there is a Community Mental Health Board which reflects citizen participation. This Board has By-Laws which provide for representation from eight districts. Denver General and Fort Logan Mental Health Center are in the process of finalizing a cancellation of their contract. Currently the Board is negotiating with Fort Logan for the provision of all the components of service. Denver General continues to supply some services in the Westwood Housing Area and to that section of Model Cities within the catchment area. While there is a possibility that Denver General could also enter into an agreement with the Southwest Denver Board, this is not likely. For the time being, however, some of the outpatient service is still supplied by Denver General in their hospital setting while inpatient service is given by Fort Logan.

Children's Hospital Association, Child Guidance Clinic, a specialized clinic dealing primarily with children, receives some funding from the Department of Institutions but remains part of a private hospital facility. It provides diagnosis, treatment and consultation to children up to eighteen year's of age. Some teaching is done by the clinic and its consultation services are offered to parents, state agencies and schools. The clinic test an estimated 85 children a month. They receive approximately $35,000 in assistance which comprises about 48 percent of the clinic's budget.

Children's and Adolescents' Mental Health Service
(formerly known as Child Guidance Clinic)
Children's Hospital Association

Total number of patients	234
Number of interviews	3,342
Hours in community service	799
Local share	$38,273
State share	35,685
Federal share	974
Total cost	$74,932

The State Plan Recommendations. The Department of Health suggests the possibility of expansion of the Fort Logan team in the southwest catchment area to develop a comprehensive center, and the future development of a community center under the auspices of the University of Colorado's Psychiatric Hospital, which is providing some mental health services now.

Included among the other facilities providing mental health services to the Denver Metropolitan area are the following:

Public or Private Psychiatrict Hospitals

Bethesda Hospital
Fort Logan Mental Health Center
Mount Airy Psychiatric Hospital
University of Colorado Psychiatric Hospital
Porter Memorial Hospital

St. Joseph Hospital
Veteran's Administration Hospital

Other facilities:

Beacon Development Center
Denver Children's Home
Family and Children's Service of Colorado
Good Shepherd Home for Girls
Jewish Family and Children's Service of Denver

Savio House
University of Denver Child Study Center
University of Denver Student Health Services
Denver Visiting Nurses Association

The southwest and northeast catchment areas of Denver are receiving mental health services from Fort Logan teams and a Denver General Hospital team.

Fort Logan's Role in Community Mental Health Care Programs

Fort Logan assumes a triple role as a mental health facility: it is a state hospital; a community mental health center for the City and County of Denver; and an integral part of surrounding metropolitan counties' community mental health programs. Since Fort Logan is a multicomponent facility its major concern is to avoid duplication of existing services. The arrangements involved in providing services become rather complex. For example, Fort Logan's emergency psychiatric service, designated the Crisis Division, accepts calls from the eight-county metropolitan area and, in contractual agreement with specific county centers, provides particular types of emergency service.

An example of the resistance to a duplication of functions can be seen in Fort Logan's outpatient service. This element is organized so that 1) those patients seeking admission to Fort Logan but requiring only outpatient treatment are referred to a community clinic or private psychiatrist; and 2) only those who have been day patients or 24-hour patients at Fort Logan are eligible to receive outpatient care at Fort Logan.

Fort Logan's Relationship with Denver. Six adult psychiatric teams at Fort Logan assigned to the Denver area serve six catchment areas. Each of these teams consists of a psychiatrist, two social workers, a psychologist, seven nurses and seven mental health technicians. The teams are an essential part of Fort Logan's treatment program as a state hospital, but they also serve as community mental health teams for the six individual catchment areas.

Fort Logan's Relationship with Other Counties. At present three county community mental health centers contract with Fort Logan to supply one or more of the five essential services to complete their facilities. These counties and their centers are: Adams, Joseph S. Gollob Adams County Mental Health Center; Arapahoe, Arapahoe Mental Health Center; and Jefferson, Jefferson County Mental Health Center. A fourth such center, the Southwest Denver Mental Health Center, in collaboration with Denver General Hospital is in the development stage. Thus, Fort Logan Mental Health Center is developing as a state hospital with

four component subparts, each of which is a separate comprehensive community mental health center.21/

The Adams County center contracts with Fort Logan to provide inpatient care and partial day hospitalization. One wing of Fort Logan is set aside for the Adams County geographic area and the Fort Logan Adams team treats patients from this area. The Adams center has a unique arrangement with Fort Logan for patients receiving partial hospitalization and those 24-hour patients who are receiving day care. These patients are "sheltered" at Fort Logan in the evenings and on weekends but are bussed to the Adams center for treatment with the Adams team from Fort Logan. In addition to these two types of patients, patients receiving outpatient day care from the Adams center also participate in the treatment program. Dr. Henry Frey, Director of the Adams County Mental Health Center, notes that this type of program accomplished two objectives: 1) the length of 24-hour care is decreased; and 2) the transition from 24-hour to day care is facilitated.

The Arapahoe County Mental Health Center also contracts with Fort Logan for inpatient care, partial-day hospitalization and emergency service. A full-time social worker acts as liaison between the Arapahoe center and Fort Logan and she divides her time between these facilities. At Fort Logan the Arapahoe team provides treatment for the 24-hour and day care patients from the Arapahoe center. In contractual agreement with the Arapahoe center, Fort Logan provides direct nightly and week-end emergency service through its Crisis Division.

The Jefferson County Mental Health Center is also affiliated with Fort Logan to complete its necessary five essential services. Inpatient care and partial hospitalization are supplied by Fort Logan and treatment is provided by the Jefferson team at Fort Logan. Particular types of emergency service from the Jefferson Center are handled by Fort Logan's Crisis Division.

The Southwest Denver Mental Health Center is not housed in an actual structure. Its administration is divided between Fort Logan and Denver General Hospital. Fort Logan team D-2 provides inpatient care, partial hospitalization and a small percentage of emergency services.

21/ Partial Hospitalization for the Mentally Ill; A Study of Programs and Problems, Joint Information Service of the American Psychiatric Service and National Association for Mental Health.

Joseph S. Gollob, Adams County Mental Health Center

The Adams County community center serves as a good example of a comprehensive mental health center.

The Adams center was built on county owned land at a cost of $239,886. The federal government paid 49.1 percent of the costs under P.L. 88-164 (The Community Mental Health Centers Act of 1963) and 50.9 percent of the cost came from holding funds made available by the Adams county commissioners. The construction began in July of 1967 and the center began operating in late February of 1968. The total operating cost for fiscal 1970 was $385,309. Approximately 2,824 patients were served and 10,557 man-hours were spent in community service during fiscal 1970.

The staff consists of five part-time psychiatrists, four full-time and three part-time psychologists, eight full-time and six part-time psychiatric social workers, two general social workers, a business manager, two secretary typists, two receptionists, and a maintenance man. The center conducts a short-term therapy, crisis-oriented operation which attempts to meet the needs of the population with immediate, direct services, using many modalities and techniques of treatment. Staff are involved not only with patient care but also with community consultation, education, and organization.

The center provides the five required elements of a community mental health center: inpatient; outpatient; emergency; partial hospitalization; and consultation and education. The Adams center has an unusual arrangement with Fort Logan. Patients from the Adams center are housed at Fort Logan for partial hospitalization and inpatient care. Five days a week these patients and an entire team from Fort Logan (assigned to Adams county) are bussed to the Adams center where the treatment takes place. The Adams center physically is divided into two sections, one for the Fort Logan patients, the other for the outpatient and other services the center provides.

The Adams center provides extensive counseling and education services. There is a marriage counseling service which in 1968 handled more than 100 couples most of which were required by the District Court judge to avail themselves of the service. In Adams county, before a divorce is final the couples are required by the court to seek counseling. In school districts surrounding the center adolescent discussion groups have been established by the staff of the center. School counselors are trained to take charge of these groups. Therapy to individual children in the school system is given upon request of a school counselor. Workshops are also held for teachers. The center staff also does evaluation of adolescents for the Juvenile Division of the District Court. Psychiatric examinations are done by the center staff on incarcerated adults at the request of the public defender's office.

The center staff works with people referred by the Adams county welfare department and provides in-service training for parent counselors in the Head Start program. In addition the center is involved with training of personnel in the field of mental health. Student nurses from Porter Memorial Hospital, graduate students in psychiatric nursing from the University of Colorado Medical School and students working on their masters degrees in social work spend time at the center as part of their on-field work placement. In summary, the Adams center appears to be providing a wide range of services to the community as was the intent of the comprehensive community mental health program concept.

Colorado Community Mental Health Funding Legislation

Mental health services are purchased from community mental health clinics and centers as provided by statute, 3-11-9 through 3-11-16, C.R.S. 1963, as amended. A method for allocating the monies which are appropriated for this purpose is also established by statute.

Formula for Funding

Purchase of Outpatient Services. Of the total amount appropriated for the purchase of mental health services, "not more than sixty cents per capita of the area covered by such services shall be used for purchase of outpatient care provided by clinics and other activities of such clinics approved by the executive director of the department of institutions."22/ The amount which is appropriated for the purchase of the above mentioned services is determined under the following formula: in the case of the 1970-71 appropriation -- the population of the state (2,074,540) times 99.6% coverage times sixty cents. Based on this formula, the 1970-71 appropriation for purchase of outpatient and related services is $1,239,745.

The state can pay for the services listed above in an amount which does not exceed sixty percent of the cost of providing such services except that during the first three years of a newly established clinic the state payment for services may be up to 75 percent of the costs.

22/ Section 3-11-10 (3)(a), C.R.S. 1963, as amended.

Purchase of Inpatient Services. In addition to the amount discussed above, which is based on a per capita formula, the state can pay up to 90 percent of the cost of providing services not listed above. The intent of the law was that this money would be used to pay for services which are provided by centers and not by clinics, namely inpatient services. Once the total amount of money appropriated for mental health services is known, the amount that can be used for outpatient services is determined based on the population, and the remainder of the appropriation can be used for purchasing inpatient services. In practice, the appropriation bill breaks the appropriation into two separate figures -- one for outpatient services, and one for inpatient services.

In the case of the 1970-71 budget, the amount appropriated for the purchase of inpatient services is $614,604. This amount is to be used for paying up to 90 percent of the cost of providing inpatient services and "shall be supplemental to income derived from private resources, insurance carriers and other public sources."23/ In other words this money is to be supplemental to money collected from patient fees, insurance payments and federal and local matching monies.

Director's Discretionary Fund. Of the total amount appropriated for the purchase of mental health services, the Director of the Department of Institutions may use up to ten percent to purchase services without regard to matching requirements or per capita limitations. Apparently, it was the intent of the General Assembly in passing this provision to give the director a certain amount of flexibility in administering funds. With these discretionary funds, the director could, for example, give some additional funds to a clinic or center which is located in a poor county and unable to come up with necessary local matching funds.

Distribution of Community Mental Health Funds to Clinics and Centers

Once the state has appropriated monies for the purchase of mental health services, the clinics and centers present their estimated budgets to the Division of Mental Health in order to qualify for state monies.

Outpatient services. All of the centers and clinics which are approved by the director provide outpatient services and in this way qualify for a share of the amount appropriated for the purchase of these services. Each center or clinic serves a certain portion of the state's population and this is the figure used in determining the amount of the per capita monies they will receive.

23/ Section 3-11-10 (5)(b), C.R.S. 1963, as amended.

After the amount to be allocated to the center or clinic has been determined, the facility enters into an agreement with the department -- the facility agreeing to provide services, activities, necessary books, records and other fiscal reports, etc., and the department agreeing to purchase services in an amount not to exceed $_____. There is a cancellation clause allowing either party to terminate the agreement with thirty days notice. But more importantly, the maximum amount written into the agreement may be increased or decreased during the term of the agreement by the Executive Director after he has consulted with the facility and given them at least thirty days notice of the intent to increase or decrease the payment. This clause is particularly important because it means that the department is not strictly bound to the amount set in the agreement and can increase or decrease that amount depending on the particular needs and circumstances of the facility.

Inpatient Services. Since only centers provide inpatient services, the state allots its inpatient appropriation to six centers -- Adams, Arapahoe, Denver General Hospital, Midwestern, Jefferson, and Weld. The law allows the state to pay up to ninety percent of the cost of providing such services and is to be supplemental to income derived from private resources, insurance carriers and other public sources. As was explained previously, centers which provide the five essential services are eligible for federal staffing grant monies. The initial federal staffing grants were given on a 51 month declining basis -- the federal government would pay 75 percent of the costs of staffing for the first 15 months of the grant, 60 percent for the next 12 months, 45 percent the next 12 months, and 30 percent the final year of the grant. The 1970 amendments to the Community Mental Health Centers Act will have an impact on federal staffing grant monies available to the centers. The monies which the state appropriates for inpatient services are used to replace the declining federal monies which the centers receive.

In order for the legislature to anticipate monies that may be needed or requested for mental health centers in the future, the Joint Budget Committee has required that "Prior to the establishment of additional mental health centers the state mental health authority shall submit to the Joint Budget Committee for approval any federal applications which will require either state matching or state replacement of the federal funds."24/

24/ Footnote #27, page 48, H.B. No. 1158, 1970 Session. This language was vetoed by the Governor.

Ten Percent Discretionary Fund

By statute, the Director of the Department of Institutions is authorized to use up to ten percent of the amount appropriated for the purchase of community mental health services for the purchase of services without regard to matching requirements or per capita limitations. While the director could rightfully withhold ten percent of the mental health appropriation and distribute it to the centers and clinics as he sees fit, this is not the way the department uses the ten percent money. As soon as the General Fund appropriation is made, the department signs agreements to purchase services totalling the full amount appropriated for this purpose. Each approved center and clinic is given an allotment which is divided into 12 equal parts to be used to reimburse the facility for the services provided. Each month the facility submits a report of its expenditures to the department. If the facility's expenditures do not require that the department pay them all of their allotted amount, the department can use that unexpended money to assist another facility which may be having difficulty in gaining local support. For example, the state's monthly payment to Clinic A is $6,000 for the purchase of outpatient services. If the clinic submits a monthly expenditure report of less than $10,000, (the state's share being 60 percent of this amount) the department can use its savings from Clinic A to provide assistance to Clinic B which may be in financial trouble.

This discretionary monies always come from savings from the outpatient appropriation and not from the amount appropriated for inpatient services. Since the inpatient monies are used to replace declining federal monies and this is a predictable amount, there is little flexibility in this share of the appropriation.

Local Share of the Funding

The local share of the matching monies come from a variety of sources -- county commissioners, school districts, the courts, individual contributions, United Fund monies, etc. Some of the contributions are made in return for services rendered. For example, some school districts pay the centers or clinics to run tests on pupils enrolled in their district. The courts may pay the clinics or centers for certain services, e.g., marital counseling.

1969-70 Actual Expenditures of Community Mental Health Centers and Clinics

The actual expenditures for community mental health centers and clinics are contained in Table I. The fourth column shows the amount of state dollars needed for the purchase of

outpatient services from each of the centers and clinics. This amount was based on the population of the area covered multiplied by 52¼ cents which was the per capita amount for the purchase of outpatient services in 1969-70. Column 7 shows the actual amount per capita that the state spent on purchase of outpatient services. In most instances the maximum amount the state could spend on purchase of outpatient services for each facility (52¼ cents x population) equalled the amount the state actually spent. As was explained in the section on the distribution of state funds, if a clinic or center submits expenditure reports which indicate that they are not entitled to the maximum amount of per capita outpatient funds, the Director of the Department can use these savings or unexpended funds to assist another center or clinic without regard to per capita or matching limitations.

In fiscal 1970 the total appropriation for per capita allotment to centers and clinics was $1,074,036, the estimated amount was $1,072,535 and the actual amount spent was $1,072,395. The total appropriation for state inpatient monies for fiscal 1970 was $246,225; the actual amount spent was $246,226.

Problem Areas in Mental Health Funding

Per Capita Allotment and Purchase of Services. The state constitution (Article XI, Section 2) specifically prohibits the state from giving direct grants to any corporation or company. For this reason the concept of "purchase of services" from private corporations and agencies was developed. For example, it has long been the practice of the Division of Public Welfare to purchase nursing home care for individual welfare recipients from private nursing homes. For nursing home care, the welfare division sets a ceiling on the daily amount it will pay per patient for such care. Any amount in excess of this ceiling must be paid by relatives, or from other sources.

Contrary to the individual purchase of services concept utilized by the Division of Welfare, community mental health services are purchased on a general or catchment-area basis. In a sense, the purchase of community mental health services simply is a grant-in-aid, because the state monies are allocated on an area population basis, rather than according to services performed by the centers and clinics.

The per capita grants based on catchment areas provide a stable base of income upon which the clinics can finance their activities. For instance for the fiscal year 1969-70, ten of the thirteen clinics received between 40 and 60 percent of their total operating revenues from the state. Although the clinics probably would like to see an increase in the level of per capita support, knowledge that a given level of funds will be available is essential in establishing positions and recruiting staff. For this reason, clinic representatives have given support to the per capita grant concept.

Table I

DEPARTMENT OF INSTITUTIONS COMMUNITY MENTAL HEALTH PROGRAM
ACTUAL EXPENDITURES FOR FISCAL YEAR 1969-70*

Clinic or Center	County	Actual Population 7/1/69	Actual Population x 52¼¢	Federal Staffing	Federal 314-D	Per Capita State	In-patient State	10% State	Fees	Local	Total
**Adams	Adams	163,000	$85,167	$ 164,453	$ 2,000	$85,167	$63,175	$--	$27,569	$42,945	$ 385,309
**Arapahoe	Arapahoe	138,000	77,695	258,394	--	77,696	35,936	--	66,481	44,472	482,979
	Douglas	7,100									
	Elbert	3,600									
Boulder	Boulder	112,400	58,729	--	4,590	58,729	--	--	24,260	70,687	140,702
**Denver General			140,907	2,030,458	--	140,907	66,605	--	Unknown	380,003	2,617,973
Denver MHC	Denver	493,000	41,000	--	6,193	41,000	--	--	48,479	2,622	98,294
Children's			35,685	--	974	35,685	--	--	Unknown	38,273	74,932
Bethesda			40,000	227,153	--	40,000	--	--	31,282	158,612	457,047
East Central	Cheyenne	2,400	7,890	--	1,495	7,890	--	--	1,000	1,870	12,255
	Kit Carson	7,600									
	Lincoln	5,100									
**Jefferson	Clear Creek	3,600	114,427	70,098	10,492	114,427	20,223	--	61,625	37,938	314,804
	Gilpin	700									
	Jefferson	214,700									
Larimer	Larimer	82,500	43,106	--	3,468	43,106	--	--	13,733	13,472	73,779
Mesa	Mesa	54,000	28,215	--	3,504	28,215	--	--	1,253	27,447	60,419
**Midwestern	Delta	14,400	23,277	24,098	3,072	23,277	7,700	--	2,628	16,583	76,968
	Gunnison	8,300									
	Hinsdale	200									
	Montrose	19,100									
	Ouray	1,500									
	San Miguel (½)	1,050									
Northeast	Logan	19,300	32,029	--	2,963	32,029	--	--	8,916	58,266	102,174
	Morgan	20,200									
	Phillips	4,000									
	Sedgwick	3,700									
	Washington	6,100									
	Yuma	8,000									
Northwest	Moffat	6,800	6,688	--	3,747	6,688	--	--	2,014	21,933	34,382
	Routt	6,000									

Table I
(Continued)

Clinic or Center	County	Actual Population 7/1/69	Actual Population x 52¼¢	Federal Staffing	Federal 314-D	Per Capita State	In-patient State	10% State	Fees	Local	Total
Pikes Peak	El Paso	216,100	$112,912	$ --	$ --	$105,951	$ --	$ --	$20,938	$49,697	$ 176,586
San Luis Valley			20,743	--	3,003	19,152	--	--	1,708	10,267	34,130
	Alamosa	11,500									
	Conejos	8,400									
	Costilla	3,800									
	Mineral	600									
	Rio Grande	10,900									
	Saguache	4,500									
Sopris			13,062	--	--	13,063	--	--	3,717	13,321	30,101
	Eagle	5,600									
	Garfield	15,800									
	Pitkin	3,600									
Southeast			28,371	--	--	36,785	--	--	3,405	32,665	72,855
	Baca (½)	3,150									
	Bent	6,950									
	Crowley	3,200									
	Kiowa (½)	900									
	Otero	25,700									
	Prowers	14,400									
Southwest			19,619	--	8,242	19,620	--	--	2,907	12,156	42,925
	Archuleta	2,900									
	Dolores	1,800									
	La Plata	17,100									
	Montezuma	13,700									
	San Juan	1,000									
	San Miguel (½)	1,050									
Spanish Peaks (Southern)			76,912	52,634	3,000	76,912	--	--	35,633	71,621	239,800
	Huerfano	7,400									
	Las Animas	16,800									
	Pueblo	123,000									
**Weld			43,367	132,880	4,501	43,368	52,587	--	38,074	631	272,115
	Weld	83,000									
West Central			22,728	--	--	22,728	--	--	2,031	13,628	38,387
	Chaffee	10,200									
	Custer	1,300									
	Fremont	21,600									
	Lake	9,000									
	Park	1,400									
TOTALS		2,052,700	$1,072,535	$2,960,168	$61,244	$1,072,395	$246,226	--	$396,653	$1,118,809	$5,838,913

* The information was provided by Mr. Luther Glass, Budget Officer, Division of Finance, Department of Institutions.

** Comprehensive Community Mental Health Center.

1/ The per capita amount was originally estimated by the Division at 52¼ cents, rather than on the 52½ cents which was the basis of the appropriation, to allow the Division some flexibility due to changes in population and other factors.

A major drawback to the per capita grant program is that it does not provide any mechanism for meeting specific problems of individual clinics. For instance, the cost of serving a rural population usually is much higher than providing a similar program for a concentrated population. A substantial travel budget is needed to provide consultive services in a rural community.

It is also argued that the per capita allotment bears no relationship to caseload of patients, the kinds and quality of service provided, or the effectiveness of the program. A center or clinic with a smaller catchment area may actually be serving more persons than one with a larger population to serve. Yet under the per capita funding formula, the facility with the larger catchment area will receive more state funds. The population of a community may or may not bear a relationship to the actual number of persons who are patients at the treatment facility serving such catchment area. The relationship between the total population in areas served by a particular facility and the number of patients actually receiving assistance follows:

Center or Clinic	Population 7/1/69	Patients Served 1968-69 Actual*	Percent of Population Served*
**Adams	163,000	2,056	1.26%
**Arapahoe	148,700	1,108	.75
Boulder	112,400	767	.68
**Denver General Denver Mental Health Center Children's	493,000	6,438	.13
East Central	15,100	11	.07
Gunnison-Hinsdale[1]	8,500	108	1.27
**Jefferson	219,000	1,044	.48
Larimer	82,500	911	1.10
Mesa	54,000	691	1.28
**Midwestern	36,050	207	.57
Northeast	61,300	1,169	1.91
Northwest	12,800	124	.97
Pikes Peak	216,100	725	.34
San Luis	39,700	329	.83
Sopris	25,000	69	.28

Center or Clinic	Population 7/1/69	Patients Served 1968-69 Actual*	Percent of Population Served*
Southeast	54,300	265	.49 %
Southwest	37,550	277	.74
Spanish Peaks	147,200	572	.39
**Weld	83,000	573	.69
West Central	43,500	597	1.37

* Based on patient figures reported in the Budget Requests 1970-1971, Division of Mental Health, Department of Institutions.

** Community mental health center.

1/ Gunnison-Hinsdale Guidance Center merged with the Midwestern Mental Health Center in May, 1969.

Local Effort. In purchasing services from local mental health facilities, the state does not take into consideration the amount of effort or ability of the local community to provide funds. The following per capita figures for the local share of expenditures for mental health clinics show a wide range in the per capita amount of local monies contributed from one community to another:

	Fiscal Year 1969-70		
Clinics	Population	Local Per Capita	State Per Capita
Boulder	112,400	$ .63	$.52 1/4
Denver MHC	*	*	.52 1/4
Children's	*	*	.52 1/4
Bethesda	*	*	.52 1/4
East Central	15,100	.12	.52 1/4
Larimer	82,500	.16	.52 1/4
Mesa	54,000	.51	.52 1/4
Northeast	61,300	.95	.52 1/4
Northwest	12,800	1.71	.52 1/4
Pikes Peak	216,100	.30	.49
San Luis Valley	39,700	.26	.52 1/4
Sopris	25,000	.50	.52 1/4
Southeast	54,300	.60	.68
Southwest	37,550	.32	.52 1/4
Spanish Peaks	147,200	.49	.52 1/4
West Central	43,500	.31	.52 1/4

* It is impossible to compute accurate local per capita amounts for these facilities as there are no defined boundaries for the local population.

The state's per capita contribution (1969-70) remained at 52 1/4 cents for most of the centers despite the amount of local effort being made. The state reduced the amount of money spent at Pikes Peak to 49 cents because the clinic's expenditures did not warrant the state spending the full per capita amount. The state's per capita amount was increased to 68 cents at Southeast because the clinic could not raise local funds to meet demands for staff. The amount of per capita local effort ranges from a low of .12 cents for the East Central clinic to a high of $1.71 per capita for the Northwest clinic at Hayden.

Complicating the problem further is that local monies are collected from a variety of sources. Since local funds include Medicare, Medicaid, school district, welfare, and other public monies, both the state and federal governments are actually providing some of the local funding. In any event, there is no specific tax effort required of the local communities to match state funds for mental health services.

Again, since the state pays clinics for services on a per capita basis, little consideration is given to the financial ability of the communities to provide their local share. A clinic in a "wealthy county" like Jefferson (1968 per capita income $2,735) receives the same amount as the clinic in Costilla County (1968 per capita income $554).

Cost of Providing Services. Since clinics differ in the services they provide and the amount of time spent on each type of service, expenditures vary from facility to facility. For example, the staffs of some clinics spend a great deal of time on consultation and education in the community. These costs cannot be directly related to patient caseload. However, if total clinic or center costs are related to the number of patients treated, a wide range of costs per patient treated results. For instance, for the centers, such costs range from $136 (Adams) to $434 (Arapahoe), while for the clinics the range of costs per patient treated vary from $90 (West Central) to $565 (Denver Mental Health Center.) As would be expected, on the whole, the centers which provide costly inpatient services have higher per patient costs, $269, compared to $187 for the clinics. Nevertheless, some clinics have higher average per patient costs than centers which offer a wider variety and more expensive services.

	(1) Number of Patients[1]	(2) Total Costs of Center or Clinic[1]	(3) Col.(2) ÷ Col.(1)[2]
**Adams	2,824	$385,309	$136
**Arapahoe	1,112	482,979	434
Boulder	804	140,702	175
**Denver General	8,804	2,617,973	297
Denver Mental Health Center	174	98,294	565
Bethesda	556	457,047	822
Children's	234	74,932	320
East Central	91	12,255	135
**Jefferson	994	314,804	317
Larimer	676	73,779	109
Mesa	487	60,419	124
**Midwestern[3]	387	76,968	199
Northeast	908	102,174	113
Northwest	123	34,382	280
Pikes Peak	787	176,586	224
San Luis	162	34,130	211
Sopris	146	30,101	206
Southeast	363	72,855	201
Southwest	309	42,925	139
Spanish Peaks	907	239,800	264
**Weld	1,285	272,115	212
West Central	425	38,387	90
TOTAL	22,002	$5,381,869	$245
Center	15,406	$4,150,148	$269 ave.
Clinic	16,596	$1,231,172	$187 ave.

** Community mental health center.

1/ Based on actual figures for 1969-1970, provided by Mr. Luther Glass, Budget Officer, and Mr. Harold Nitzberg, Coordinator of Community Mental Health Programs, Department of Institutions.

2/ Figures computed by the Legislative Council staff.

3/ Gunnison-Hinsdale Guidance Center merged with the Midwestern Mental Health Center in May, 1969.

Problems Unique to Funding Centers

Fundamentally, the difference between a comprehensive center and a clinic is that a clinic provides outpatient and consultive services, while centers are charged with additional responsibility for 24-hour emergency services including inpatient care. Even though a center may have such additional programs, these services may be contracted for with another institution, suggesting that some centers operate as clinics to a large degree. In changing from a clinic to a center, substantial new monies must be made available to provide the specialized services demanded by such clinics.

Based on the populations (1970 census) of catchment areas served, the average per capita cost of operating centers for fiscal 1971-72 is estimated to be $3.84, compared to a figure of $1.69 for the clinics. (These figures were computed from the data contained in Table II.) For the eight centers listed in Table II, the per capita expenditures range from an estimated $2.44 for Jefferson Community Mental Health Center to $6.23 in the budget request of the Southwest Community Mental Health Center. The thrust of the budget request of the Southwest Center is a specialized program dealing with alcoholics. The Southwest program currently is operating as a clinic, and total per capita operating costs for fiscal year 1970 and 1971 are estimated to be a $1.15 and $1.86 respectively. The Boulder Clinic also is requesting additional monies for operation as a center. Their current per capita expenditures, $1.28 for fiscal 1970-71, would increase to $5.60 under plans for operation as a center in 1971-1972.

The major cost of operating a center is salaries for personnel. Federal staffing grants currently cover a large portion of such operating expenditures. For example, of the $4,150,148 spent in six comprehensive centers -- Adams, Arapahoe, Denver General, Jefferson, Midwest and Weld -- for fiscal year 1969-70, $2,700,446 was financed from federal funds; the vast majority of which was for staffing grants. (The first two years of a staffing grant, the federal government will pay up to 75 percent of costs; 60 percent for the third year; 45 percent for the fourth year; and 30 percent for the last four years of the grant.) For Colorado centers, for fiscal 1972, the federal staffing percentages are expected to range from 30 to 75 percent (See Table III). With the variation in the level of federal funds available, flexibility needs to be maintained in any formula developed for state participation. The flat per capita grants simply do not meet the needs of the centers.

The total estimated expenditures for fiscal 1971-1972 for the centers listed in Table III amounts to $6,986,189. The federal government is expected to pay for 47 percent of the cost of these programs -- roughly $3,258,010. Eventually the state of Colorado may have to assume the major share of this entire program, plus the additional expense of other centers which may be formed.

Table II

ACTUAL AND ESTIMATED TOTAL PER CAPITA EXPENDITURES OF CLINICS AND CENTERS FOR FISCAL YEARS 1970, 1971, AND 1972[1]

Clinic or Center	1970 Census Population Served	Total Expenditures Act. 1969-70 Amount	Act. 1969-70 Per Capita	Est. 1970-71 Amount	Est. 1970-71 Per Capita	Est. 1971-72 Amount	Est. 1971-72 Per Capita
Adams**	187,787	$ 385,309	$ 2.05	$ 494,660	$ 2.63	$ 589,000	$ 3.14
Arapahoe**	174,310	482,979	2.77	648,729	3.72	788,586	4.52
Boulder*	134,134	140,702	1.05	171,962	1.28	750,952	5.60
East Central	14,358	12,255	.85	12,868	.90	13,897	.97
Jefferson**	258,020	314,804	1.22	402,242	1.56	628,931	2.44
Larimer	88,664	73,779	.83	87,850	.99	103,700	1.17
Mesa	52,598	60,419	1.15	100,019	1.90	105,000	2.00
Midwest**	42,533	76,968	1.81	104,567	2.46	110,327	2.59
Northeast	59,242	102,174	1.72	114,836	1.94	120,577	2.04
Northwest	12,724	34,382	2.70	35,501	2.79	37,276	2.93
Pikes Peak	229,113	176,586	.77	324,747	1.42	330,747	1.44
San Luis Valley	36,373	34,130	.94	43,070	1.18	50,844	1.40
Sopris	27,695	30,101	1.09	34,963	1.26	52,643	1.90
Southeast	48,752	72,855	1.49	78,997	1.62	82,947	1.70
Southwest*	37,404	42,925	1.15	69,400	1.86	233,194	6.23
Spanish Peaks*	138,913	239,800	1.73	281,320	2.03	316,108	2.28
Weld**	89,086	272,115	3.05	329,142	3.69	345,599	3.88
West Central	40,898	38,387	.94	49,928	1.22	55,163	1.35
TOTALS	$1,672,604	$2,590,670	$ 1.51 average	$3,384,801	$ 1.91 average	$4,715,491	$ 2.64 average

1/ Table does not include community mental health centers or clinics located in Denver because the catchment areas are not easily identified. The information in this table was obtained from Mr. Luther Glass, Budget Officer, Division of Mental Health, Department of Institutions.

* Clinics applying for federal money to become centers.

** Centers, established prior to 1969-70.

Table III

ESTIMATED FEDERAL AND STATE EXPENDITURES FOR COMMUNITY MENTAL HEALTH CENTERS

Fiscal Year 1971-1972[1]

Center	1972 Federal Staffing Percentage	Total Estimated Expenditures of Centers[2]	Total Tentative Est. Fed. Funds Required[3]	Col. 3 ÷ Col. 2	Amount of State Funds Required[4]	Col. 5 ÷ Col. 2
Adams	30%	$ 589,000	$ 120,000	20%	$ 382,000	65%
Arapahoe	30%	790,760	258,312	33%	281,091	36%
Boulder	75%	750,952	338,276	45%	190,758	25%
Denver General	30%	3,537,426	2,126,184	60%	592,383	17%
Jefferson	30%	628,931	63,500	10%	459,754	73%
Midwest	60%	110,327	48,167	44%	43,661	40%
Southwest	75%	233,194	144,481	62%	38,053	16%
Weld	30%	345,599	159,090	46%	95,955	28%
TOTALS		$6,986,189	$3,258,010	47%	$2,083,661	30%

1/ All of the figures presented below are tentative estimates utilized for discussion purposes only.

2/ These figures were obtained from the Division of Mental Health, in its tentative budget for 1971-72 with the single exception of Denver General which was provided by Mr. Bill Frieder, Deputy Manager, Department of Health and Hospitals, City and County of Denver.

3/ These figures were provided by each of the centers.

4/ These figures were obtained from the Division of Mental Health in its tentative budget for 1971-72.

COMMUNITY CENTER PROGRAMS FOR THE MENTALLY RETARDED

Since special education programs serve only the educable handicapped within certain age groups, other programs have been developed at the local level to attempt to meet the need for other than institutional care. Community center programs seek to fill much of the need at the local level.

Comparison of Community Center and Special Education Programs

Confusion often exists over the difference between special education and community center programs. The following outline clarifies the distinctions between the two functions.[25]

COMMUNITY CENTER	SPECIAL EDUCATION
A program for Trainable Mentally Retarded	A program for Educable Mentally Retarded
DEFINITION	
A Community Centered program is one in which the continuum of care, including services and resources for mentally retarded and seriously handicapped persons, is coordinated through the planned efforts and cooperation of a community incorporated board.	A School Directed program for Mentally Retarded, Visually, Acoustically, Orthopedically Handicapped, Educationally Handicapped including perceptually and emotionally, Home or hospitalized programs, Health problems, and Home to School telephone.
STATE AGENCY WITH JURISDICTION	
Department of Institutions	Department of Education
LOCAL AGENCY WITH JURISDICTION	
Community Center Board	School Board
Members:	Members:
Community Center Board choses and replaces own members	Elected by voters in District

25/ Source: Louise Johnstone, Coordinator, Jefferson County Community Center.

Comparison of Community Center and Special Education Programs, continued

FUNDING

H.B. 1386, 1969 Session allows for an appropriation of up to 75% of cost. (Full funding has not yet been provided.)

Section 123-22-11 (b), C.R.S. 1965 Supp, provides reimbursement of 80% of a certified teachers salary to the Board of Education. (The yearly appropriation actually provides 55-65% of stated reimburesement.)

LONG RANGE GOALS

Sheltered Employment in a workshop or Employment in the community.

Social and economic independence.

OBJECTIVES

Provide training in:
- Self-help skills
- Social skills
- Academic areas
- Vocational skills
- Language and communication
- Practical Arts
- Motor development

Provide training in:
- Social skills
- Academic skills
- Vocational skills
- Work-training program

QUALIFICATIONS FOR ENROLLMENT

Mentally retarded and seriously handicapped persons of any age requiring specialized services to meet their individual needs which are not provided by law at the community level through regularly established tax supported programs.

Ages - 3 to retirement

I.Q. - essentially 50 and below (trainable)

Persons in one or more of following categories:
MR 50-80 I.Q. (Educable)
Deaf
Orthopedically Handicapped
Visual problems
Perceptual problems
Emotional problems

Ages - 3 to 21

Comparison of Community Center and Special Education Programs, continued

PROGRAMS OFFERED

Nursery School - under 3	Elementary, (age 5 - up)
Pre-School, 3 - 7	Junior High
Day Training, 6 - 18	Senior High
Sheltered Workshop, 16 and over	Work Training
Social Adjustment, 3 - 21	
Purchase of Service, Any age from other Centers	

The Community Centers Law in Colorado

In 1964, the General Assembly passed the first measure providing for reimbursement to community incorporated boards for the purchase of services for the mentally retarded and seriously handicapped. The framework of this 1964 legislation remains in effect today. The law provides that the boards can purchase services from public or private nonprofit sheltered workshops, day care training centers, or other private facilities; or, the community boards may develop and operate services themselves.

As the law read in 1964, payments from state funds for such services could not exceed fifty percent of the annual cost per trainee, exclusive of capital construction, but not to exceed $500 per year. In 1967, this amount was changed to sixty percent of the total annual cost of the community centered program, and in 1969, the maximum was increased to seventy-five percent.

The law also provides that a sum not to exceed ten percent of the total amount appropriated for the program can be used by the office of the Executive Director of the Department of Institutions to purchase services without regard to matching requirements.

A valuation is placed on personal services and materials in kind which are contributed to community centers; this valuation cannot exceed one-half of the required community share of total cost of services. The law states that local governmental units, such as school districts, can purchase services from the centers or otherwise provide money or services to centers.

Growth of Community Center Mental Retardation Programs

Since 1964, community center programs have expanded both in number of actual facilities and in counties of the state served, and in number of patients enrolled. The following statistics indicate this growth pattern:

	FY 1966	FY 1967	FY 1968	FY 1969	FY 1970
No. of Community Boards	14	19	22	23	23
Counties Served	21	25	28	30	33
Caseload	857	1,204	1,308	1,529	1,857

With few exceptions enrollment in community center programs is not expected to increase markedly in rural areas. The greatest increases in enrollment are expected in El Paso, Denver, Pueblo, and Larimer counties. Two exceptions of rural areas showing significant increases are Morgan and Sedgwick counties.

With further implementation of the community placement plan administered jointly by the Department of Institutions and the Department of Social Services, it is anticipated that the number of retardates served by community boards will continue to increase. Based on appropriations for the placement plan for fiscal 1970, it is estimated that some 430 retardates from the state's three institutional facilities can be placed during the current fiscal year.

Community Center Enrollment by Program. Table IV on page 54 shows, by program and fiscal year, the enrollment at community programs directed by the state's 23 community boards. The figures indicate that day training programs constitute the largest share of the community programs -- an estimated 60 percent of those served by community boards in fiscal year 1970 will be enrolled in day training programs.

Eligibility for Community Center Programs

Mentally retarded and seriously handicapped persons eligible for services provided by community center boards are those persons of any age requiring specialized services to meet needs not provided by law at the community level through regularly established tax supported programs. Three groups are specifically excluded from support by community center boards:

1) School-age children capable of being educated effectively through regular classroom instruction;

2) School-age children eligible (educable handicapped) to participate in the special programs for the education of handicapped children under Colorado law; and

3) Persons eligible for services provided by the State Department of Rehabilitation.

Level of Functioning of Patients Served by Community Programs

Community centers for the mentally retarded serve only those retardates classified as "trainable"; "educable" children are enrolled in special education classes conducted by the school districts. The level of functioning of individuals in community programs in 1968-69, by county, is provided in Table V, page 55. The table shows that half (49.2%) of the retardates enrolled in center programs are moderately retarded (I.Q. 36-51) and that 61 percent have an I.Q. below 52, the mild categorization of retardation.

The functioning and ability levels for the moderately retarded are described as follows:

Maturation and Development -- Noticeable delays in motor development, especially in speech; responds to training in various self-help activities.

Training and Education -- Can learn simple communication, elementary health and safety habits and simple manual skills; does not progress in functional reading or arithmetic.

Social and Vocational Adequacy. Can perform simple tasks under sheltered conditions; participates in simple recreation; travels alone in familiar places; usually incapable of self-maintenance.

The figures below show a comparison of the level of functioning between those retardates enrolled in community center programs and those at the state's three institutional facilities for the period 1967-69.

	Unknown	Profound	Severe	Moderate	Mild	Borderline
Community Centers	8.8	2.6	19.4	49.2	15.5	4.5
Ridge	1.0	47.6	20.2	17.1	10.2	---
Grand Junction	---	36.7	19.2	22.1	16.8	5.2
Pueblo	6.96	22.6	20.29	35.58	12.82	---

The figures confirm the fact that community programs are serving the less severely retarded while the institutional facilities, for the most part, are serving greater numbers of the profoundly and severely retarded.

Table IV

COMMUNITY CENTER ENROLLMENT BY PROGRAM

County	NURSERY, PRE-SCHOOL, HOMEBOUND			DAY TRAINING			PRE-VOCATION, WORKSHOP, SOCIALIZATION			TOTAL ENROLLMENT		
	Actual	Estimated		Actual	Estimated		Actual	Estimated		Actual	Estimated	
	'68-69	'69-70	'70-71	'68-69	'69-70	'70-71	'68-69	'69-70	'70-71	'68-69	'69-70	'70-71
Adams	22	30	36	75	109	110	51	34	49	148	173	195
Arapahoe	16	22	26	58	112	114	52	60	64	126	194	204
Arkansas Valley	11	12	12	12	18	18	1	10	10	24	40	40
Boulder	14	20	25	53	55	60	30	30	40	97	105	125
Cheyenne	-	-	-	3	3	3	-	-	-	3	3	3
Delta	-	-	-	15	18	22	-	-	-	15	18	22
Denver	60	65	68	213	249	299	153	169	160	426	483	527
El Paso	40	20	30	83	120	140	25	23	41	148	163	211
Fremont	-	-	-	12	13	14	24	24	26	36	37	40
Huerfano	-	-	-	12	15	16	-	-	-	12	15	16
Jefferson	22	21	21	79	88	88	40	63	54	141	172	163
La Plata	-	-	-	8	12	12	-	-	-	8	12	12
Larimer	8	14	16	19	24	35	8	18	31	35	56	82
Las Animas	7	-	-	13	35	40	11	-	-	31	35	40
Logan	-	-	-	14	17	14	-	-	8	14	17	22
Mesa	-	-	-	17	20	24	-	-	-	17	20	24
Montezuma-Delores	1	-	-	7	8	9	-	-	-	8	8	9
Montrose	24	-	-	-	25	35	-	-	-	24	25	35
Morgan	2	-	-	6	14	20	9	9	20	17	23	40
Prowers	1	-	-	24	27	27	-	-	-	25	27	27
Pueblo	24	26	29	37	68	75	33	40	44	94	134	148
San Luis Valley	-	-	-	-	-	24	-	-	-	-	-	24
Sedgwick	-	-	-	23	36	30	-	-	10	23	36	40
Weld	6	7	7	21	24	24	30	30	30	57	61	61
TOTALS	258	237	270	804	1,110	1,253	467	510	587	1,529	1,857	2,110
PERCENT OF TOTAL ENROLLMENT	17%	13%	13%	53%	60%	59%	30%	27%	28%	100%	100%	100%

Source: Division of Mental Retardation, Department of Institutions.

Table V

LEVELS OF FUNCTIONING
1968-1969

County	Untestable	Profound 0-20	Severe 21-35	Moderate 36-51	Mild 52-67	(Seriously Handicapped) Borderline 68-83	Total Enrollment
ADAMS	20	3	24	66	27	8	148
ARAPAHOE	10	3	15	64	24	10	126
BENT, CROWLEY, OTERO	3	1	2	14	4	-	24
BOULDER	20	1	15	35	14	12	97
CHEYENNE	-	-	3	-	-	-	3
DELTA	-	-	4	11	-	-	15
DENVER	20	18	125	192	56	15	426
EL PASO	14	5	23	67	29	10	148
FREMONT	1	-	5	26	3	1	36
HUERFANO	-	-	-	8	4	-	12
JEFFERSON	13	5	20	78	21	4	141
LA PLATA	1	-	1	6	-	-	8
LARIMER	5	-	5	19	5	1	35
LAS ANIMAS	2	-	6	14	6	3	31
LOGAN	-	-	2	7	4	1	14
MESA	2	-	2	9	4	-	17
MONTEZUMA, DOLORES	-	-	2	6	-	-	8
MONTROSE	5	-	-	11	6	2	24
MORGAN	-	-	3	8	6	-	17
PROWERS	1	-	8	12	4	-	25
PUEBLO	16	1	17	49	11	-	94
SEDGWICK	1	-	3	18	1	-	23
WELD	-	2	12	33	8	2	57
TOTALS	134	39	297	753	237	69	1,529
PERCENT OF TOTAL	8.8%	2.6%	19.4%	49.2%	15.5%	4.5%	100%

Examples of Community Mental Retardation Programs

An examination of community mental retardation programs offered by two community boards gives an indication of the kind of services provided directly by the boards and those services purchased by the boards for mental retardates within the board's jurisdiction.

Jefferson County Center, Inc.

The Jefferson County Community Center was initiated in 1962 as a pilot program. It was officially established and funded in 1964 at which time there was a two morning a week pre-school for children 3-5 years of age, an afternoon pre-school every day of the week, three day a week training classes, and a sheltered workshop program. Total enrollment in 1964 was 62 trainable mental retardates; staff consisted of six paid employees, a volunteer coordinator, and a bookkeeper. The facility was in a church basement with offices in a greenhouse.

In 1969, the Center's schedule consisted of daily morning and afternoon pre-school training classes six days per week, morning and afternoon daily social adjustment sessions, and a sheltered workshop for 50 trainees. Services were purchased in other facilities for 20 children.[26] Total enrollment for 1969 was expected to be 170. Staff consists of 31 paid individuals and 18 Red Cross volunteers. The facility is now in a school building in Wheat Ridge rented from the school district. The sheltered workshop is housed in a building in Arvada which is purchased by the Community Center Board.

In addition to the program outlined above, the following services are provided for those under the Jefferson County Center's jurisdiction: bussing for all pre-school children, hot lunch, a part-time speech therapist and physical education teacher, and a full-time social worker.

26/ The Division of Mental Retardation's 1969-70 Directory of Services provided at the community level indicates that the Jefferson County Community Center purchases services from the following facilities: Broomfield Foundation for Retarded Children, United Cerebral Palsy Center, Laradon Hall School for Exceptional Children, Scottdale for Children, Suburban Community Training and Services Center, Inc., and Wesley D. White Center.

The cost per trainee in 1968-69, including the value of all donated services and materials, was $1,264. The actual cash cost per trainee was $1,050. In 1969-70, the anticipated total cost is $1,300 which the actual cash cost is $1,140. In 1970-71, the total cost is estimated at $1,560 and the actual cash cost at $1,400.

The curriculum at the Jefferson County facility is geared to training for employment either at the Center's sheltered workshop or in the local community. Skills taught include vocational, social, self-help, reading, and numbers. Because of limited learning ability and the judgment that other skills are more important for future employment, traditional academics are secondary in the Center program. Parent-teacher conferences are held twice a year. The Trainable Mentally Retarded Performance Profile is used once a year for evaluation.

Denver Board for the Mentally Retarded and Seriously Handicapped Inc.

The community incorporated board which directly serves and purchases services for the trainable mentally retarded in Denver is the Denver Board for the Mentally Retarded and Seriously Handicapped, Inc.27/ As of June, 1969, the Denver Board was either providing directly or purchasing services for 395 trainable mentally retarded. The age groups of this total figure are as follows:

Age Groups	Number Served
Birth - 2	2
3 - 7	63
8 - 16	218
17 - 20	60
21 - 40	48
41 - Over	4
Total	395

27/ The Board provides direct services through the Denver Board School and purchases services, according to the Division of Mental Retardation's Directory, from the following facilities: Beacon Developmental Center, United Cerebral Palsy Center, Hope Center, Laradon Hall for Exceptional Children, Scottsdale for Children, Sewall Rehabilitation Center, Auraria Community Center, Saturday Club, Retardates Unlimited, Inc., and Utility Workshop.

The list of individuals from the state's mental retardation institutions waiting for openings in Denver's community center program totals 163 patients:

Age Groups	Number
Birth - 2	15
3 - 7	40
8 - 16	54
17 - 20	18
21 - 40	24
41 - Over	12
Total	163

Denver Board School. Direct services are provided by the Denver Community Center Board through the Denver Board School. As of October, 1969, some 82 mental retardates were enrolled at this facility. Eight classes are programmed: orientation, primary, primary I, primary II, intermediate I, intermediate II, prevocational I, and prevocational II. Three areas of development are emphasized: motor, psycholinguistic, and socio-recreational. Emphasis for the orientation and primary classes is on motor development to accomplish self-help skills, following directions and self-identity. Primary II and intermediate II cover all three areas with emphasis; these are the students which may be accepted by Special Education or Vocational-Rehabilitation programs.

Intermediate I, and prevocational I and II place emphasis on motor development and socio-recreational ability to promote skills of work training, getting along with people and profitable use of one's time.

Funding of Community Center Programs

In fiscal year 1969-70, the state appropriation for community center programs for the mentally retarded and seriously handicapped was $1,198,000. As outlined in the 1970 Appropriations Report of the Joint Budget Committee, the 1969-70 appropriation was based on an estimated average of 1,850 retardates in community programs and was intended to provide $647 per retardate. This appropriation was a 22 percent increase over the previous year when the state per trainee amount was $585. The Division of Mental Retardation requested $1,876,988 for fiscal year 1970-71 to allow state funds amounting to $882 per retardate for an estimated 2,110 retardates to be served. The actual 1970-71 appropriation was $1,433,900 intended to provide $760 per retardate for 1,886 enrollees in community center programs.

The following tables provide a comparison of the estimated allocations and program costs for fiscal years 1970 and 1971. While the tables provide only estimates of costs for fiscal 1970, and the 1971 figures are based on the requested appropriation, they are nevertheless helpful for purposes of comparison and analysis. Actual program cost figures for fiscal 1970 are not available. The tables that follow contain figures that were presented by the Division of Mental Retardation when they presented their budget request in December, 1969.

Comparison of Fiscal Year 1970 Estimated Costs and Fiscal Year 1971 Budget Estimates for Community Center Programs. During the 1970 fiscal year the total estimated cash program cost for community center programs was $2,129,684. It was estimated that a total of 1,857 retardates would be served in community programs during fiscal 1970. Using these estimates, the total cash cost per retardate would be about $1,146. However, the centers experienced less population than was estimated and the subsequent effect of this reduction was that more money was spent per retardate.

In its budget request for fiscal year 1970-71, the Division estimated that the total cash program cost for community centers would be $3,137,458. The Division estimated that 2,110 retardates would be served in 1970-71 bringing the total cash cost per retardate to $1,487 based on the estimates.

A brief comparison of some of the figures contained in Tables VI and VII point out some of the serious questions which arise in the funding of community centers. Some of these problems include: substantial increases in cash program costs from year to year with no relative growth in number of trainees served; wide variation in program costs from center to center; the lack of relationship of the cost of trainees to programs and local funds to state funds. A brief example of each of these problem areas follows.

Increased Cash Expenditures. Of those community center programs whose number of trainees it is estimated will remain constant for both fiscal 1970 and 1971, the following figures show the increases in cash program cost and state appropriations:

County	Trainees	Cash Program Cost		State Appropriations	
		1970	1971	1970	1971
Bent, Crowley, Otero	40	$37,120	$60,800	$25,000	$40,000
Cheyenne	3	4,500	5,000	3,000	3,000
La Plata	12	15,226	18,000	10,500	12,000
Prowers	27	32,865	52,759	21,000	26,700

TABLE VI

AMENDED ESTIMATES OF ALLOCATIONS AND PROGRAM COSTS FOR COMMUNITY CENTERED PROGRAMS, FISCAL 1970

(1) Counties	(2) Number of Trainees	(3) Total Program Cost Including Cash Program Cost & Value of Donated Services[1]	(4) Estimated Cash Program Cost	(5) Local Share	(6) % of Total Estimated Cash Program Cost Locally Funded[1]	(7) Federal Share[2]	(8) % of Total Estimated Cash Program Cost Federally Funded[1]	(9) State Share	(10) % of Total Estimated Cash Program Cost State Funded[1]	(11) % of Total Program Cost From Local, Federal, & State Cash Sources[1]	(12) Estimated Value of Donated Services	(13) % of Total Program Cost From Locally Donated Services[1]
Adams	173	$ 292,730	$ 230,430	$ 94,432	40.98%	$ 30,998	13.45%	$ 105,000	45.57%	78.72%	$ 62,300	21.28%
Arapahoe	198	213,823	166,323	53,660	32.26	7,663	4.61	105,000	63.13	77.79	47,500	22.21
Bent, Crowley, Otero	40	43,120	37,120	12,120	32.65	--	--	25,000	67.35	86.09	6,000	13.91
Boulder	105	188,840	148,840	48,500	32.59	33,340	22.40	67,000	45.01	78.82	40,000	21.18
Cheyenne	3	4,500	4,500	1,500	33.33	--	--	3,000	66.66	100.00	--	--
Delta	18	29,155	21,630	10,630	49.14	--	--	11,000	50.86	74.19	7,525	25.81
Denver	483	559,026	529,098	195,151	36.88	43,947	8.31	290,000	54.81	94.65	29,928	5.35
El Paso	163	218,112	207,188	108,188	52.22	--	--	99,000	47.78	94.99	10,924	5.01
Fremont	37	71,543	68,543	41,627	60.73	5,916	8.63	21,000	30.64	95.81	3,000	4.19
Huerfano	15	18,450	14,650	5,150	35.15	--	--	9,500	64.85	79.40	3,800	20.60
Jefferson	172	247,126	219,526	92,726	42.24	27,800	12.66	99,000	45.10	88.83	27,600	11.17
La Plata	12	20,246	15,226	4,726	31.04	--	--	10,500	68.96	75.20	5,020	24.80
Larimer	56	81,376	66,710	19,510	29.25	3,200	4.79	44,000	65.96	81.98	14,666	18.02
Las Animas	35	54,875	47,375	20,775	43.85	4,100	8.66	22,500	47.49	86.33	7,500	13.67
Logan	17	26,335	20,755	6,255	30.14	--	--	14,500	69.86	78.81	5,580	21.19
Mesa	20	20,612	15,966	4,266	26.72	--	--	11,700	73.28	77.46	4,646	22.54
Montezuma-Dolores	8	18,150	12,825	4,675	36.45	650	5.07	7,500	58.48	70.66	5,325	29.34
Montrose	30	43,155	35,605	17,605	49.44	2,000	5.62	16,000	44.94	82.50	7,550	17.50
Morgan	26	24,193	24,193	6,593	27.25	1,600	6.62	16,000	66.13	100.00	--	--
Prowers	27	32,865	32,865	2,510	7.64	9,355	28.46	21,000	63.90	100.00	--	--
Pueblo	134	149,272	107,402	20,620	19.20	5,600	5.21	81,182	75.59	71.95	41,870	28.05
Sedgwick	24	36,620	30,620	10,620	34.68	5,000	16.33	15,000	48.99	83.62	6,000	16.38
Weld	61	75,794	72,294	28,094	38.86	5,200	7.19	39,000	53.95	95.38	3,500	4.62
TOTALS	1,857	$2,469,918	$2,129,684	$809,933	38.03%	$186,369	8.75%	$1,133,382	53.22%	86.22%	$340,234	13.78%

1/ Calculation of percentages was done by the Legislative Council staff.
2/ Federal funds not used for matching state funds.

TABLE VII

REVISED ESTIMATES OF ALLOCATIONS AND PROGRAM COSTS FOR COMMUNITY CENTERED PROGRAMS, FISCAL YEAR 1971

(1) Counties	(2) Number of Trainees	(3) Total Program Cost Including Cash Program Cost & Value of Donated Services[1]	(4) Estimated Cash Program Cost	(5) Local Share	(6) % of Total Estimated Cash Program Cost Locally Funded[1]	(7) Federal Share[2]	(8) % of Total Estimated Cash Program Cost Federally Funded[1]	(9) Requested State Share	(10) % of Total Estimated Cash Program Cost State Funded[1]	(11) % of Total Program Cost From Local, Federal, & State Cash Sources[1]	(12) Estimated Value of Donated Services	(13) % of Total Program Cost From Locally Donated Services[1]
Adams	195	$ 390,389	$ 336,389	$107,726	32.02%	$ 29,663	8.82%	$ 199,000	59.16%	86.17%	$ 54,000	13.83%
Arapahoe	204	223,000	173,000	50,000	28.90	8,000	4.63	115,000	66.47	77.58	50,000	22.42
Bent, Crowley, Otero	40	68,300	60,800	18,900	31.08	1,900	3.13	40,000	65.79	89.02	7,500	10.98
Boulder	125	251,883	221,883	54,883	24.74	34,000	15.32	133,000	59.94	88.09	30,000	11.91
Cheyenne	3	5,000	5,000	2,000	40.00	--	--	3,000	60.00	100.00	--	--
Delta	22	37,453	29,953	11,453	38.24	--	--	18,500	61.76	79.97	7,500	20.03
Denver	527	843,249	812,749	242,500	29.84	40,749	5.01	529,500	65.15	96.38	30,500	3.62
El Paso	211	326,715	316,715	167,315	52.83	--	--	149,400	47.17	96.94	10,000	3.06
Fremont	40	76,999	73,999	49,999	67.57	--	--	24,000	32.43	96.10	3,000	3.90
Huerfano	16	24,560	20,860	5,860	28.09	--	--	15,000	71.91	84.93	3,700	15.07
Jefferson	175	314,860	282,460	97,000	34.34	16,500	5.84	168,960	59.82	89.71	32,400	10.29
La Plata	12	27,800	18,000	6,000	33.33	--	--	12,000	66.66	64.75	9,800	35.25
Larimer	70	197,790	168,790	34,400	20.38	45,500	26.96	88,890	52.66	85.34	29,000	14.66
Las Animas	40	62,999	55,499	20,099	36.21	10,400	18.74	25,000	45.05	88.10	7,500	11.90
Logan	22	34,510	29,510	6,444	21.84	--	--	23,066	78.16	85.51	5,000	14.49
Mesa	24	22,000	17,000	5,000	29.41	--	--	12,000	70.59	77.27	5,000	22.73
Montezuma-Dolores	9	21,920	16,170	5,050	31.23	700	4.33	10,420	64.44	73.77	5,750	26.23
Montrose	35	66,434	58,434	22,005	37.66	2,000	3.42	34,429	58.92	87.96	8,000	12.04
Morgan	40	39,928	39,928	10,128	25.37	--	--	29,800	74.63	100.00	--	--
Prowers	27	52,759	52,759	16,309	30.91	9,750	18.48	26,700	50.61	100.00	--	--
Pueblo	148	251,854	197,854	72,000	36.39	7,000	3.54	118,854	60.07	78.56	54,000	21.44
San Luis Area	24	26,500	26,500	5,776	21.80	--	--	20,724	78.20	100.00	--	--
Sedgwick	40	45,012	39,012	7,012	17.97	7,000	17.95	25,000	64.08	86.67	6,000	13.33
Weld	61	88,194	84,194	18,249	21.67	11,200	13.30	54,745	65.03	95.46	4,000	4.54
TOTALS	2,110	$3,500,108	$3,137,458	$1,036,108	33.02%	$224,362	7.15%	$1,876,988	59.83%	89.64%	$362,650	10.36%

1/ Calculation of percentages was done by the Legislative Council staff.
2/ Federal funds not used for matching state funds.

With the exception of Cheyenne, all of the other centers listed above show larger increases in cash program costs and state appropriations for the same number of trainees for fiscal 1971 as for fiscal 1970. Bent, Crowley and Otero cash program costs increase in 1971 by an estimated $23,680 while the state funds are requested to increase by $15,000. La Plata is estimated to increase $2,774 in the cash program cost and the state is requested to increase its funds by $1,500. And Prowers cash program cost is estimated to increase by $19,894 with a state increase of $5,700.

Wide Variation in Program Costs. The following examples illustrate the apparent lack of continuity between costs per retardate in the various centers throughout the state. For example, based on the fiscal 1971 budget request the Delta center will accommodate four more trainees than in 1970 with a cash program increase of $7,500. On the other hand, Mesa trainees will number four more than in 1970, the same increase it is estimated that Delta will realize, but the cash program cost increase is estimated at $1,034. Finally, Jefferson center trainees are estimated to increase by three with an increase in cash program cost of $62,934.

Lack of Relationship of State and Local Funds. Denver provides a good illustration of this problem. The Denver Community Center program for fiscal 1970 is serving an estimated 483 trainees at a total program cost of $559,026, and a total cash program cost of $529,098. The state appropriation is $290,000; the local funding is estimated at $195,151. In fiscal 1971, based on the budget request, the number of trainees is expected to be 527 (a 44 increase over fiscal year 1970) with a total program cost of $843,249 (a $284,223 increase). For fiscal year 1971, the state is requested to fund $529,500 (a $239,500 increase over fiscal year 1970), and local funding is estimated at $242,500 (an increase of $47,349 over fiscal year 1970). The cash cost per trainee for Denver county in 1970 is estimated to be $1,095; in 1971, $1,542. The cost in state money per trainee in Denver in 1970 is estimated at $600; in 1971, this per trainee figure increases to $1,005.

Allocation of State Funds to Community Center Programs

While the state law provides that the state may pay up to 75 percent of the annual costs of approved community center programs, there is a wide variation in the percentage of program costs payed for by state monies among the centers. For example, Table VI illustrates that for fiscal year 1969-70, the state percentage of total estimated cash programs costs ranged from a high of 75.59 percent in Pueblo, to a low of 30.64 percent in Fremont. This wide range in state funding has generated considerable concern about the allocation of state funds to community center programs.

In an attempt to clear up some of the confusion over the distribution of state funds to community centers, Marvin Meyers, Chief of the Division of Mental Retardation, prepared a memorandum explaining how funds are distributed. Basically, Mr. Meyers explains that allocations are made on an individual "grant-type" basis. Each year the department reviews the budget requests of every center and takes into consideration such things as program success, specific local problems, addition of trained personnel, etc., in making its allocation.

The problems of the funding of the community centers for the mentally retarded are very similar to the problems related to the funding of community mental health centers. In the area of mental health, the actual funding appears to have little relationship to such things as local effort, financial ability of the community, cost of providing services, etc. Perhaps the system of allocating funds on an individual "grant-type" basis was an attempt to consider some of these factors. However, this method of allocating funds has been criticized because it could become somewhat arbitrary since there are no set standards for how money will be allocated.

1970-71 Appropriation and Allocation. The General Fund appropriation for community centers for the mentally retarded for fiscal year 1971 is $1,433,900. The 1971 Appropriations Report of the Joint Budget Committee explains that this appropriation is intended to provide $760 per trainee for an estimated 1886 students in ADA in 1970-71. The 1969-70 appropriation was designed to provide an average of $647 per student in ADA. In fact, however, the state share of expenditures for fiscal year 1969-70 averaged $718 per trainee.

Because the method of allocating funds on a "grant-type" basis has been a subject of criticism, the Division of Mental Retardation decided to devise a new method of allocating state funds to centers. The Division contemplated distributing funds on the basis of the average daily attendance (ADA) of the previous year plus a 20 percent growth factor. The decision to allocate funds on the basis of ADA was rejected and the Division decided to allocate funds on the basis of average daily enrollment or membership (ADM) rather than attendance. The rationale for this decision was that retarded and severely handicapped persons have a high rate of absenteeism and it is unfair to fund the centers on the basis of attendance because it does not realistically reflect the number of persons actually receiving training at the centers. There has been much dissatisfaction among the centers concerning the revised method of funding. Some centers were satisfied with the funding on the basis of enrollment; others preferred that distribution be made on the basis of attendance; some preferred the former "grant-type" basis; and still others suggested that the Division devise a different, more equitable method.

In order to compute the amount centers will receive under ADM, the Division has taken an average of the total enrollment from the centers for the months September, 1969 through April, 1970. The enrollment figures were taken from monthly reports submitted by the centers and reflect total enrollment in all programs through April, 1970. For the 1970-71 allocations, the Division added ten percent to the ADM. Ten percent reflects the actual percentage increase in enrollment from fiscal year 1969 to fiscal year 1970.

Comparison with 1969-70 Allocation. The following table compares funding on the basis of ADA and ADM with the actual amounts of state funds centers received for fiscal year 1969-70. It should be noted that the allocation under ADM represents the initial allocation which will be given to the centers. Enrollments will be reviewed periodically and allotments may be increased or decreased depending on whether the center's enrollment has risen or fallen from the anticipated level. In order to allow for a discretionary fund to be distributed without regard to matching, the per pupil allotment is $750 rather than the $760 which is allowed for in the state appropriation.

Funding on the Basis of Average Daily Attendance. At the time the Division of Mental Retardation was planning to fund on the basis of average attendance, the Division had informed the centers of the formula that would be used to determine the allotment they would receive. The Division used each center's highest attendance report for the time period September 1969 through February 1970, plus a 20 percent growth factor multiplied by $750. Apparently, the 20 percent growth factor is an arbitrary figure.

Under the ADA formula of funding, nine centers would have received an amount which is less than their allotment for 1969-70. Centers which would have received less monies under this formula include the Bent, Crowley, Otero center, ($4,975 less than 1969-70), Cheyenne ($450), Denver ($22,100), Fremont ($5,550), Huerfano ($875), La Plata ($2,625), Larimer ($18,650), Montezuma-Dolores ($3,600), and Montrose ($1,900). The primary reason for such decreases is that allocations have not been based solely on the number of trainees served in the past and centers have not been hurt if their enrollment fell below estimates. For fiscal year 1970-71, however, centers which have low enrollment and attendance will receive smaller allocations as the amount they receive will be based entirely on the number of trainees served.

Funding on the Basis of Average Daily Membership (Enrollment). Under the revised method of funding based on average enrollment, eight centers will receive less state funds than they received in 1969-70. The centers which will receive

TABLE VIII

COMPARISON OF FISCAL YEAR 1970-71 FUNDING OF COMMUNITY CENTERS FOR THE RETARDED USING ADA AND ADM WITH ALLOCATIONS FOR FISCAL YEAR 1969-70*

Center	(1) Estimated No. of Trainees	(2) 1969-70 State Funds	(3) 1970-71 ADA (1969-70 ADA + 20%)	(4) 1970-71 ADA x 750	(5) Increase or Decrease from 1969-70	(6) 1970-71 ADM (1969-70 ADM + 10%)	(7) 1970-71 ADM x 750	(8) Increase or Decrease from 1969-70	(9) ADM Compared to ADA Formula
Adams	173	$ 105,000	173.8	$ 130,350	$+25,350	185	$ 138,750	$+ 33,750	$+ 8,400
Arapahoe	198	105,000	144.4	108,300	+ 3,300	155	116,250	+ 11,250	+ 7,950
Bent, Crowley, Otero	40	25,000	26.7	20,025	- 4,975	26	19,500	- 5,500	- 525
Boulder	105	67,000	108.4	81,300	+14,300	111	83,250	+ 16,250	+ 1,950
Cheyenne	3	3,000	3.4	2,250	- 750	4	3,000	-0-	+ 750
Delta	18	11,000	16.0	12,000	+ 1,000	17	12,750	+ 1,750	+ 750
Denver	483	290,000	357.2	267,900	-22,100	385	288,750	- 1,250	+20,850
El Paso	163	99,000	182.7	137,025	+38,025	176	132,000	+ 33,000	- 5,025
Fremont	37	21,000	20.6	15,450	- 5,550	18	13,500	- 7,500	- 1,950
Huerfano	15	9,500	11.5	8,625	- 875	10	7,500	- 2,000	- 1,125
Jefferson	172	99,000	156.7	117,525	+18,525	160	120,000	+ 21,000	+ 2,475
La Plata	12	10,500	10.5	7,875	- 2,625	9	6,750	- 3,750	- 1,125
Larimer	56	44,000	33.8	25,350	-18,650	33	24,750	- 19,250	- 600
Las Animas	35	22,500	34.0	25,500	+ 3,000	33	24,750	+ 2,250	- 750
Logan	17	14,500	20.1	15,075	+ 575	17	12,750	- 1,750	- 1,175
Mesa	20	11,700	21.3	15,975	+ 4,275	22	(16,500)**	+ (4,800)**	+ (525)**
Montezuma-Dolores	8	7,500	5.2	3,900	- 3,600	7	5,250	- 2,250	+ 1,350
Montrose	30	16,000	18.8	14,100	- 1,900	25	18,750	+ 2,750	+ 4,650
Morgan	26	16,000	26.1	19,575	+ 3,575	24	18,000	+ 2,000	- 1,575
Prowers	27	21,000	30.4	23,175	+ 2,175	30	22,500	+ 1,500	- 675
Pueblo	134	81,182	124.8	93,600	+12,418	118	88,500	+ 7,318	- 5,100
Sedgwick	24	15,000	20.9	18,750	+ 3,750	21	15,750	+ 750	+ 3,000
Weld	61	39,000	59.8	44,850	+ 5,850	62	46,500	+ 7,500	+ 1,650
TOTALS	1,857	$1,133,382	1,607.1	$1,208,475	$+75,093	1,648	$1,236,000	$+102,618	$+27,525

* The figures on ADA and ADM pupil figures and allotments were provided by the Division of Mental Retardation. The calculations of the increase or decrease were prepared by the Legislative Council Staff.

** The state funds to the Mesa Center will be reduced from the ADM amount ($16,000) to $12,000 because this is the amount they request.

less under ADM are: Bent, Crowley, Otero ($5,500), Denver ($1,250), Fremont ($7,500), Huerfano ($2,000), La Plata ($3,750), Larimer ($19,250), Logan ($1,750), and Montezuma-Dolores ($2,250). Furthermore, a total of eleven centers will receive less under the ADM formula than they would have received under ADA. While some centers will benefit from the ADM formula, (e.g., Denver will receive $20,850 more than under ADA) other centers will actually receive less by counting membership rather than attendance. (The Division is currently negotiating with the centers who received less to adjust their allotments upward in order to allow them to continue their programs at least on the level of the previous year.) The explanation for why enrollment figures should be less in some cases than attendance is that for the ADA the center's highest attendance figure was used with a 20 percent growth factor added, while for membership, an average of the actual enrollments for the past eight months plus a ten percent growth factor was used.

Comparison of Estimated Enrollment With Average Enrollment Realized

One problem which has arisen repeatedly in the community centered program for the mentally retarded is the determination of meaningful caseload figures. Since no figures have been compiled on growth trends since the program began, it is difficult to predict how much enrollments will increase from year to year. Because of lack of adequate statistical data and information concerning unmet needs, centers have oftentimes "shot high" in estimating enrollments. Table IX illustrates the differences between predicted and actual enrollments of the centers, which illustrates the need for more accurate and meaningful statistical data both for budgetary purposes and assisting in program evaluation.

State Funds. The General Assembly appropriated $1,198,000 for 1969-70 community center programs for the mentally retarded. The 1969-70 Appropriations Report of the Joint Budget Committee, page 82, explains that the appropriation was based on an estimated average 1,750 students plus an additional 100 students expected from community placements from institutions for a total caseload of 1,850 students. The appropriation was intended to provide state support for these 1,850 students at $647 per student.

The figures presented by the Director of Community Center Programs at Joint Budget Committee hearings in November and December, 1969, indicated that $1,133,382 state monies had been allocated to the centers to provide support for an estimated 1,857 students. Using these figures, the average per pupil state support would be $610. Actual enrollment figures

TABLE IX

Fiscal Year 1969-70

COMPARISON OF STATE PER PUPIL ALLOTMENTS BASED ON ESTIMATED NUMBER OF TRAINEES AND ACTUAL AVERAGE DAILY ENROLLMENT

Centers	Actual State Funds Allocated[1]	Estimated No. of Trainees[1]	State Per Pupil Allotment Est. Enrollment[2]	Actual Average Daily Membership[3]	State Per Pupil Allotment Actual Enrollment[2]
Adams	$ 105,000	173	$607	168	$625
Arapahoe	105,000	198	530	141	745
Bent, Crowley, Otero	25,000	40	625	24	1,042
Boulder	67,000	105	638	101	663
Cheyenne	3,000	3	1,000	3	1,000
Delta	11,000	18	611	15	733
Denver	290,000	483	600	352	824
El Paso	99,000	163	607	160	619
Fremont	21,000	37	568	16	1,313
Huerfano	9,500	15	633	9	1,056
Jefferson	99,000	172	576	145	683
La Plata	10,500	12	875	8	1,313
Larimer	44,000	56	786	30	1,467
Los Animas	22,500	35	643	30	750
Logan	14,500	17	853	15	967
Mesa	11,700	20	585	20	585
Montezuma-Dolores	7,500	8	938	6	1,250
Montrose	16,000	30	533	18	888
Morgan	16,000	26	615	22	727
Prowers	21,000	27	778	26	808
Pueblo	81,182	134	606	107	759
Sedgwick	15,000	24	625	21	714
Weld	39,000	61	639	56	696
TOTALS and STATE-WIDE AVERAGES	$1,133,382	1,857	610 Ave.	1,479	766 Ave.

1/ Based on figures presented to the Joint Budget Committee by the Director of the Community Center Programs. (See Memorandum No. 5, Table II, page 17.)
2/ Calculated by the Legislative Council staff.
3/ Calculated by the Division of Mental Retardation based on actual enrollment records for September, 1969 through April, 1970.

for the months of September 1969 through April, 1970, indicate that many centers have fallen short of their anticipated enrollments. Rather than the estimated enrollment of 1,857, centers have realized an average enrollment of 1,479. Since the allotments have not been adjusted in light of the decrease in enrollment, the state per pupil allotment on the basis of 1,479 amounts to $766. For some centers which have had a much lower actual enrollment than they anticipated, there has been a substantial increase in state per pupil support. For example, the Fremont center estimated that it would serve 37 trainees and the amount of state funds received would have allowed $568 per pupil for these 37 students. Thus for this fiscal year, Fremont has realized an average enrollment of 16 pupils. State funds divided among this number averages $1,313 per pupil. Other centers which show a significant difference in estimated number of students and actual average enrollments are:

Center	Estimated Enrollment	Average Enrollment
Arapahoe	198	141
Bent, Crowley, Otero	40	24
Denver	483	352
Larimer	56	30

Some of the centers with smaller enrollments illustrate the even more dramatic increases in per pupil dollars.

Center	State Per Pupil Based on Estimated Enrollment	State Per Pupil Based on Average Enrollment
Bent, Crowley, Otero	$ 625	$ 1,042
Huerfano	633	1,056
La Plata	875	1,313
Montezuma-Dolores	938	1,250

Summary and Conclusions

Table VIII, which compares the amount of funds the centers receive under the various methods of distribution, demonstrates that in the past state monies distributed to the centers have had little relationship to number of persons served. This year, for the first time funds will be distributed on the basis of number of pupils served. While the numbers served may not be the best method of distributing monies since there are so many variables in the operation of centers, such as differences in program cost, salaries, etc., it nevertheless points up the need for data on program costs and meaningful standards upon which funds are distributed.

Question of School District Assistance to Community Center Programs for the Mentally Retarded and Seriously Handicapped

Local School Districts' Responsibility

Many groups and individuals have charged that local school districts have shirked their responsibility for providing training or education for trainable mentally retarded and seriously handicapped persons. They point to Article IX, Section 2 of the Colorado Constitution which states that "...a system of free public schools..." is to be established "...wherein all residents of the state, between the ages of six and twenty-one years, may be educated gratuitously."

In many cases the gap has been filled by local community boards in establishing centers and purchasing services for the retarded and handicapped. However, because local boards usually lack adequate funds to meet program expenses, parents are oftentimes required to pay part of the expense of their child's training. If the child were normal, school programs would be available at no cost to the family.

Committee members expressed an interest in obtaining data on the contributions of local school districts to programs of the community centers for the trainable mentally retarded and seriously handicapped. The Committee requested the staff to make a comparison between local property tax expenditures for education for normal children and the expenditures by respective school districts for the handicapped children in attendance at community centers. To accomplish this objective, the staff requested each center to provide data on:

(1) the number of school-age children in each center and their respective school districts;

(2) the amount of cash contributions made by the school district;

(3) the amount of in-kind contributions (facilities, transportation, testing services, etc.) made by each school district; and

(4) the basis upon which the contributions are made.

This information then was compared to school district average daily attendance and property tax income data.

Cash Contributions Made by School Districts to Community Centers

Of the 23 community centers in existence in Colorado in 1969-70, the Council staff received information from all but one center. The centers replying to the questionnaire reported that school-age children (six to 21) attended the centers from a total of 74 school districts. Of these 74 districts, 53 or 72 percent provide some cash moneys to the centers to support their program. Table X lists the contributions of the centers and establishes a comparison of these contributions with the local school tax effort. In 18 districts the cash donations to the centers are the same or exceed the local financial effort made by the respective district on behalf of the normal child.

Contributions by the School Districts for In-kind Services

If the value of "in-kind services" provided by the districts is added to the cash donations by the districts, the local effort of the school districts on behalf of centers is greater. For instance, of the 60 school districts which provide some kind of assistance, the total value of cash and in-kind aid exceeds the local tax effort for a normal child in 23 districts or about 38 percent of the time (see Table XI). Furthermore, in 48 of the 60 school districts providing monies or services in-kind in 1969-70, the total value of such services amounted to more than one-half the local tax effort for a normal child. Thus when in-kind assistance is considered, most school districts are making a substantial effort on behalf of children in the community centers. Furthermore, school district support of the centers is growing. One school district, district 60 in Pueblo County, which made a minimum effort in 1969-70, reportedly will contribute $150 in cash per student for fiscal 1970-71.

Potential Costs to School Districts of Expanded Community Center Programs

In considering the possibility of requiring school districts to make a contribution to community center programs on the basis of local tax effort for normal children, the legislature may wish to consider potential maximum costs of these programs. For instance, the school-age enrollment reported by the 22 centers totals 1,237 children for 1969-70. Department of Institutions personnel, on the other hand, believe that there is a potential enrollment for the centers of 5,500 school-age children. In other words, with continued reduction of the number of children in two state institutions, but more importantly with expanded services, growth in center populations is expected. If the needs of all the trainable and seriously handicapped school-age children were met, costs to the school districts would, of course, be greater. Table XII attempts to outline the maximum possible costs to the school districts, based on 1969-70 data,

of any commitment of school district funds on behalf of children in community programs. If such commitment is based on comparative local effort for a normal child, this could mean a total estimated expenditure of $2,265,598 state-wide. In no instance, however, would a school district be expected to levy more than 0.75 of a mill. The average mill levy state-wide for such a program would amount to 0.40 of a mill. In considering this maximum possible impact projected in Table XII, the General Assembly may wish to take into consideration that the projections are based on the assumption that those in need of community services would be equally divided among the school districts of the state. Furthermore, a more conservative estimate of the possible expansion of community center programs probably would be more realistic, suggesting that future costs will actually range somewhere between the current levels as reflected in Tables X and XI and the maximum program projected in Table XII.

Table X

ESTIMATED IMPACT TO SCHOOL DISTRICTS FOR MAINTAINING CASH ASSISTANCE FOR SUPPORT OF HANDICAPPED IN COMMUNITY CENTERS AT A LEVEL EQUAL TO LOCAL SCHOOL SUPPORT FOR A NORMAL CHILD[a]
Fiscal 1969-1970

Center	School District	(1) No. of School-age Enrollees	(2) Total Cash Assistance From Dist.	(3) Amount Per Pupil (Col. 2 ÷ Col. 1)	(4) Gen. Prop. Tax Raised Per ADAE	(5) Col. 4 Less Col. 3[b]	(6) Total Effort Proposed for District[c]
ADAMS							
	#1	14	$ 4,100	$ 293	$ 368	$ 75	$ 1,050
	12	38	7,805	205	292	87	3,306
	14	38	7,722	203	324	121	4,598
	27J	8	2,500	313	355	42	336
	50	47	9,964	212	270	58	2,726
ARAPAHOE - SUBURBAN							
	#28	29	7,945	274	298	24	696
	Cherry Creek 5	4	1,690	423	632	209	836
	Douglas Re 1	2	552	276	480	204	408
	Englewood 1	13	3,461	266	555	289	3,757
	Jefferson	2	--	--	411	411	822
	Littleton	22	6,467	294	406	112	2,464
	Sheridan 2	5	1,496	299	315	16	80
	Denver	3	--	--	649	649	1,947
BENT - CROWLEY - OTERO - ARKANSAS							
	Las Animas Re-1	3	900	300	347	47	141
	Crowley, Lincoln 1-J	2	--	--	414	414	414
	La Junta R-1	15	--	--	308	308	4,620
	Rocky Ford R-2	4	1,000	250	262	12	48
	Fowler R-4J	2	1,200	600	363	-237	--
	Swink 33	1	--	--	321	321	321
BOULDER							
	B. Valley	45	20,097	447	541	94	4,230
	St. Vrain Valley	12	5,735	478	423	-55	--
CHEYENNE							
	Kit Carson	3	2,225	775	775	--	--

Table X
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Total Cash Assistance From Dist.	(3) Amount Per Pupil (Col. 2 ÷ Col. 1)	(4) Gen. Prop. Tax Raised Per ADAE	(5) Col. 4 Less Col. 3[b]	(6) Total Effort Proposed for District[c]
DELTA							
	50	15	$ 3,687	$ 246	$ 301	$ 55	$ 825
DENVER							
	Denver	342	146,599	429	650	221	75,582
EL PASO							
	Harrison 2	6	3,480	580	193	-387	--
	Security 3	11	5,800	527	152	-375	--
	Fountain 8	8	3,560	445	52	-393	--
	Colo. Springs 11	93	42,407	456	277	-179	--
	Cheyenne Mtn. 12	1	580	580	788	208	208
	Manitou Springs 14	1	580	580	504	-76	--
	Air Academy 20	2	1,160	580	76	-504	--
	Lewis Palmer 38	1	580	580	380	-200	--
FREMONT - NEW HOPE							
	Re 1 Canon City	8	--	--	340	340	2,720
	Re-J2 Florence	7	--	--	273	273	1,911
	Buena Vista	1	--	--	192	192	192
HUERFANO							
	Re-2 La Veta	1	--	--	549	549	549
	Re-1 Walsenburg	7	500	71	285	214	1,498
JEFFERSON							
	R-1	128	37,348	292	412	120	15,360
LA PLATA							
	9-R Durango	8	--	--	392	392	3,136
	11-J Ignacio	2	1,350	675	178	-497	--
LARIMER							
	Poudre R-1	15	6,000	400	495	95	1,425
	Thompson R-2J	8	3,200	400	363	-37	--

Table X
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Total Cash Assistance From Dist.	(3) Amount Per Pupil (Col. 2 ÷ Col. 1)	(4) Gen. Prop. Tax Raised Per ADAE	(5) Col. 4 Less Col. 3b/	(6) Total Effort Proposed for District c/
LAS ANIMAS							
	Trinidad 1	20	$ 6,000	$ 300	$ 182	$ -118	$ --
	Hoehne	2	1,000	500	507	7	14
	Aguilar	3	300	100	364	264	792
	Primero	3	1,000	333	661	328	984
LOGAN - HARTS, INC.							
	Re-1 Sterling	15	1,500	100	520	420	6,300
	Re 4 Merino	1	--	--	593	593	593
	Haxtun	1	385	385	794	409	409
MESA							
	Mesa	21	--	--	377	377	7,917
MONTEZUMA - MONTELORES							
	Montezuma - Cortez	5	7,500	1,500	286	-1,214	--
	Dolores	1	--	--	220	220	220
MORGAN							
	Fort Morgan Re-3	7	1,400	200	504	304	2,128
	Brush Re-2	7	1,400	200	426	226	1,582
	Woodlin	1	--	--	1,401	1,401	1,401
PROWERS - BACA							
	Holly	2	400	200	486	286	572
	Wiley	2	800	400	417	17	34
	Campo	1	--	--	658	658	658
	Walsh	2	800	400	543	143	286
	Kim	1	--	--	1,016	1,016	1,016
	Granada	3	1,200	400	410	10	30
	Lamar	12	4,800	400	301	-99	--
	Springfield	1	--	--	571	571	571
PUEBLO							
	70	10	3,000	300	258	-42	--
	60	80	4,000	50	326	276	22,080
SEDGWICK							
	Revere School	1	700	700	799	99	99
	Julesburg	1	500	500	716	216	216

Table X
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Total Cash Assistance From Dist.	(3) Amount Per Pupil (Col. 2 ÷ Col. 1)	(4) Gen. Prop. Tax Raised Per ADAE	(5) Col. 4 Less Col. 3[b]	(6) Total Effort Proposed for District[c]
WELD							
	Re-9 Alt	1	$ --	$ --	$ 756	$ 756	$ 756
	Re-3J1 Keensburg	1	--	--	352	352	352
	Re-4 Windsor	1	--	--	453	453	453
	Re-8 Fort Lupton[d]	1	2,908[d]	2,908[d]	247	-2,661	--
	Re-2 Eaton, Baleton	1	--	--	466	466	466
	Re-1 Gilcrest	1	--	--	335	335	335
	6 Greeley	24	7,344	306	394	88	--

a/ Source: Survey of community centers and school district financial data prepared by Colorado Association of School Boards.

b/ This column simply provides the amount of money raised at the local level per estimated average daily attendance which is in excess of the amount of cash assistance provided by a district for a child in a community center. The minus sign simply means that the district is providing more moneys to the centers than the tax levy per ADAE.

c/ If each district were required to provide cash assistance to a community center at an amount equivalent to the property tax per ADAE, the amount shown in Column 6 would be the additional effort needed by the district in 1969-70.

d/ Some assistance provided for children under schoolage. Fort Lupton school district provides funds for five children of preschool age.

Table XI

COMPARISON OF TOTAL CASH AND IN-KIND EFFORT FOR CHILDREN IN COMMUNITY CENTERS COMPARED TO TOTAL LOCAL SCHOOL TAX EFFORT FOR EQUIVALENT NUMBER OF NORMAL CHILDREN[a]

Fiscal 1969-1970

Center	School District	(1) No. of School-age Enrollees	(2) Prop. Tax Effort Per ADAE	(3) Proposed School Effort Col. 1 X Col. 2	(4) Assistance Provided by District: Cash	(5) Assistance In-Kind[b]	(6) Total Assistance	(7) Percent of Proposed Effort Col. 6 ÷ Col. 3
ADAMS								
	1	14	$ 368	$ 5,152	$ 4,100	$ 4,000	$ 8,100	157%
	12	38	292	11,096	7,805	2,000	9,805	88
	14	38	324	12,312	7,722	3,500	11,222	91
	27J	8	355	2,840	2,500	--	2,500	88
	50	47	270	12,690	9,964	11,000	20,964	165
ARAPAHOE	28	29	298	8,642	7,945	1,800	9,745	113
	Cherry Creek 5	4	632	2,528	1,690	50	1,740	69
	Douglas 1	2	480	960	552	--	552	58
	Englewood	13	555	7,215	3,461	100	3,561	49
	Jefferson	2	411	822	--	--	--	--
	Littleton	22	406	8,932	6,467	100	6,567	74
	Sheridan	5	315	1,575	1,496	50	1,546	98
	Denver	3	649	1,947	--	--	--	--
BENT								
	Las Animas Re 1	3	347	1,041	900	--	900	86
	La Junta R-1	15	308	4,620	--	3,264	3,264	71
	Rocky Ford R-2	4	262	1,048	1,000	--	1,000	95
	Fowler R-4J	2	363	726	1,200	--	1,200	165
	Swink 33	1	321	321	--	--	--	--
	Crowley 1J	2	414	828	--	--	--	--
BOULDER								
	Boulder Valley	45	541	24,345	20,097	11,938	32,035	132
	St. Vrain Valley	12	423	5,076	5,735	4,825	10,560	208
CHEYENNE								
	Kit Carson	3	775	2,325	2,225	--	2,225	96

Table XI
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Prop. Tax Effort Per ADAE	(3) Proposed School Effort Col. 1 X Col. 2	(4) Assistance Provided by District: Cash	(5) Assistance In-Kind[b]	(6) Total Assistance	(7) Percent of Proposed Effort Col. 6 ÷ Col. 3
DELTA	50	15	$ 301	$ 4,515	$ 3,687	$ 330	$ 4,017	89%
DENVER	Denver	342	650	222,300	146,599	4,000	150,599	68
EL PASO	Cheyenne 12	1	788	788	580	--	580	74
	Harrison 2	6	193	1,158	3,480	--	3,480	300
	Security 3	11	152	1,672	5,800	--	5,800	347
	Fountain 8	8	52	416	3,560	--	3,560	856
	Colo. Springs 11	93	277	25,761	42,407	--	42,407	165
	Manitou Springs 14	1	504	504	580	--	580	115
	Air Academy 20	2	76	152	1,160	--	1,160	763
	Lewis Palmer 38	1	380	380	580	--	580	152
FREMONT	Canon City Re-1	8	340	2,720	--	2,400	2,400	88
	Florence Re-J2	7	273	1,911	--	1,200	1,200	63
	Buena Vista	1	192	192	--	--	--	--
HUERFANO	La Veta Re-2	1	549	549	--	--	--	--
	Walsenburg Re-1	7	285	1,995	500	270	770	38
	Aguilar Re-6	--	--	--	--	350	350	--
JEFFERSON	R-1	128	412	52,736	37,348	7,400	44,748	85
LA PLATA	Durango 9-R	8	392	3,136	--	4,300	4,300	137
	Ignacio 11-J	2	178	356	1,350	--	1,350	379
LARIMER	Poudre R-1	15	495	7,425	6,000	--	6,000	81
	Thompson 2J	8	363	2,904	3,200	--	3,200	110

Table XI
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Prop. Tax Effort Per ADAE	(3) Proposed School Effort Col. 1 X Col. 2	(4) Assistance Provided by District: Cash	(5) Assistance In-Kind[b]	(6) Total Assistance	(7) Percent of Proposed Effort Col 6 ÷ Col. 3
LAS ANIMAS								
	Trinidad 1	20	$ 182	$ 3,640	$ 6,000	$ --	$ 6,000	165%
	Hoehne	2	507	1,014	1,000	--	1,000	99
	Aguilar	3	364	1,092	300	300	600	55
	Primero	3	661	1,983	1,000	500	1,500	76
LOGAN								
	Sterling Re-1	15	520	7,800	1,500	--	1,500	19
	Merino Re-4	1	593	593	--	--	--	--
	Haxtun	1	794	794	385	--	385	48
MESA								
	Mesa	21	377	7,917	--	Substantial Amount N.A.	N.A.	N.A.
MONTEZUMA								
	Montezuma - Cortez	5	286	1,430	7,500	1,000	8,500	594
	Dolores	1	220	220	--	--	--	--
MORGAN								
	Fort Morgan Re-3	7	504	3,528	1,400	3,600	5,000	142
	Brush Re-2	7	426	2,982	1,400	--	1,400	47
	Woodlin	1	1,401	1,401	--	--	--	--
PROWERS								
	Holley	2	486	972	400	--	400	41
	Wiley	2	417	834	800	--	800	96
	Campo	1	658	658	--	575	575	87
	Walsh	2	543	1,086	800	240	1,040	96
	Kim	1	1,016	1,016	--	--	--	--
	Granada	3	410	1,230	1,200	450	1,650	134
	Lamar	12	301	3,612	4,800	800	5,600	155
	Springfield	1	571	571	--	400	400	70
PUEBLO								
	70	10	258	2,580	3,000	2,700	5,700	221
	60	80	326	26,080	4,000	1,500	5,500	21

Table XI
(Continued)

Center	School District	(1) No. of School-age Enrollees	(2) Prop. Tax Effort Per ADAE	(3) Proposed School Effort Col. 1 X Col. 2	(4) Assistance Provided by District: Cash	(5) Assistance In-Kind[b]	(6) Total Assistance	(7) Percent of Proposed Effort Col. 6 ÷ Col. 3
SEDGWICK								
	Revere	1	$ 799	$ 799	$ 700	$ --	$ 700	88%
	Julesburg	1	716	716	500	--	500	70
WELD								
	Alt - 9	1	756	756	--	--	--	--
	Keenesburg Re-3J1	1	352	352	--	--	--	--
	Winsor Re-4	1	453	453	--	--	--	--
	Fort Lupton Re-18[c]	1	247	247	2,908	3,223	6,131[c]	2,482[c]
	Baleton Re-2	1	466	466	--	--	--	--
	Gilcrest Re-1	1	335	335	--	--	--	--
	Greeley #6	24	394	9,456	7,344	4,500	11,844	125

a/ Source: Survey of community centers and school district financial data prepared by Colorado Association of School Boards.

b/ Values reported by the centers for services provided by a school district. These services include facilities, transportation, personnel, etc.

c/ Fort Lupton school district provides funds for five children of preschool age.

Table XII

POSSIBLE FINANCIAL EFFORT REQUIRED OF SCHOOL DISTRICTS, BASED UPON LOCAL TAX LEVIES FOR NORMAL CHILDREN, IF A MAXIMUM LEVEL OF COMMUNITY CENTER SERVICES WERE PROVIDED TO HANDICAPPED CHILDREN[a]

	County and District	(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
ADAMS							
1	Mapleton	6,640.2	72.8	$ 368	26,790	$ 49,937,340	0.53
12	Eastlake-Northglenn	12,662.8	138.9	291	40,419	63,706,050	0.63
14	Adams City	8,422.5	92.3	324	29,905	44,431,380	0.67
27J	Brighton	3,476.9	38.1	355	13,525	25,401,120	0.53
29J	Bennett	278.4	3.0	580	1,740	4,615,881	0.37
31J	Strasburg	200.5	2.1	740	1,554	3,796,176	0.40
50	Westminster	15,069.5	165.3	269	44,465	66,477,540	0.66
ALAMOSA							
RE-11J	Alamosa	2,357.2	25.8	289	7,456	16,815,285	0.44
RE-22J	Sangre de Cristo	241.3	2.6	462	1,201	2,660,980	0.45
ARAPAHOE							
1	Englewood	5,907.3	64.8	555	35,964	56,986,181	0.63
2	Sheridan	2,036.6	22.3	315	7,024	11,136,579	0.63
5	Cherry Creek	6,773.7	74.3	631	46,883	65,380,365	0.71
6	Littleton	15,535.3	170.4	405	69,012	109,263,400	0.63
26J	Deer Trail	137.8	1.5	919	1,378	3,556,006	0.38
28J	Aurora	17,561.9	192.6	298	57,394	100,922,516	0.56
32J	Byers	211.6	2.3	982	2,258	6,035,857	0.37
ARCHULETA							
50Jt	Pagosa Springs	736.7	8.0	289	2,312	7,506,065	0.30

Table XII
(Continued)

County and District		(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additiona. Mill Levy Required
BACA							
RE-1	Walsh	516.0	5.6	$ 542	3,035	$ 8,487,263	0.35
RE-3	Pritchett	109.0	1.1	1,231	1,354	3,331,822	0.40
RE-4	Springfield	591.8	6.4	571	3,654	8,039,604	0.45
RE-5	Vilas	77.3	.8	1,418	1,134	2,317,681	0.48
RE-6	Campo	160.0	1.7	658	1,118	2,354,375	0.47
BENT							
RE-1	Las Animas	1,182.5	12.9	347	4,476	9,815,063	0.45
RE-2	McClave	216.9	2.3	677	1,557	5,282,638	0.29
BOULDER							
RE-1	St. Vrain Valley	9,240.3	10.1	422	4,262	81,858,560	0.05
RE-2	Boulder Valley	20,958.2	229.9	541	124,375	214,850,935	0.57
CHAFFEE							
R-31	Buena Vista	1,037.9	11.3	192	2,169	8,119,360	0.26
R-32J	Salina	1,399.1	15.3	276	4,222	13,581,120	0.31
CHEYENNE							
R-1	Kit Carson	167.0	1.8	774	1,393	6,668,456	0.20
R-2	Cheyenne Wells	302.3	3.3	841	2,775	5,832,334	0.47
R-3	Arapahoe	90.9	.9	917	825	2,880,540	0.28
CLEAR CREEK							
RE-1	Idaho Springs	1,127.0	12.3	669	8,228	27,993,420	0.29
CONEJOS							
RE-1J	North Conejos	1,313.3	14.4	166	2,390	5,826,860	0.41
RE-6J	Sanford	354.7	3.8	148	562	1,656,825	0.33
RE-10	South Conejos	871.4	9.5	100	950	4,097,900	0.23

Table XII
(Continued)

County and District		(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
COSTILLA							
R-1	Centennial	683.0	7.4	$ 204	1,509	$ 3,174,825	0.47
R-30	Sierra Grande	290.0	3.1	314	973	3,163,605	0.30
CROWLEY							
RE-1J	Crowley County	705.7	7.7	414	3,187	7,972,835	0.39
CUSTER							
C-1	Custer County	219.8	2.4	604	1,449	4,294,815	0.33
DELTA							
50-J	Delta County	3,539.0	38.8	300	11,640	25,660,779	0.45
DENVER							
R-1	Denver	90,133.9	988.7	649	641,666	1,314,272,210	0.48
DOLORES							
RE-1J	Dolores County	463.5	5.0	437	2,185	5,339,550	0.40
DOUGLAS							
RE-1	Douglas County	2,325.5	25.5	480	12,240	22,736,884	0.53
EAGLE							
RE-50J	Eagle County	1,456.6	15.9	676	10,748	23,093,716	0.46
ELBERT							
C-1	Elizabeth	342.7	3.7	355	1,314	2,275,482	0.57
2	Kiowa	140.3	1.5	681	1,021	2,659,727	0.38
100J	Big Sandy	309.2	3.3	609	2,010	5,255,752	0.38
200	Elbert	125.3	1.3	470	611	1,557,023	0.39
300	Agate	68.4	.7	1,186	830	3,702,484	0.22

Table XII
(Continued)

	County and District	(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
EL PASO							
R-1J	Calhan	239.9	2.6	504	1,310	$ 2,548,811	0.51
2	Harrison	4,956.0	54.3	193	10,479	22,137,270	0.47
3	Security	7,050.4	77.3	152	11,750	21,416,340	0.54
8	Fountain	2,588.0	28.3	52	1,472	5,645,400	0.26
11	Colorado Springs	29,421.1	322.7	277	89,388	262,719,620	0.34
12	Cheyenne Mountain	2,037.8	22.3	788	17,572	29,271,390	0.60
14	Manitou Springs	1,101.5	12.1	504	6,098	11,589,390	0.52
20	Air Academy	3,897.7	4.2	76	319	12,493,270	0.02
22	Ellicott	225.0	2.4	345	8828	1,660,400	0.49
23Jt	Peyton	99.4	1.1	795	874	1,156,021	0.75
28	Hanover	38.3	.4	1,617	647	2,050,590	0.31
38	Lewis Palmer	641.3	7.0	380	2,660	5,077,070	0.52
49	Falcon	211.0	2.3	507	1,166	1,953,520	0.59
54J	Edison	58.0	.6	993	596	1,810,750	0.32
60J	Miami-Yoder	124.7	1.3	609	792	2,669,580	0.29
FREMONT							
RE-1	Canon City	2,873.6	31.5	340	10,710	22,690,945	0.47
RE-2J	Florence	1,438.5	15.7	272	4,270	10,630,615	0.40
RE-3	Cotopaxi	120.6	1.3	661	859	2,294,715	0.37
GARFIELD							
RE-1J	Roaring Fork	2,751.9	30.1	334	10,053	29,150,499	0.34
RE-2	Rifle	1,256.0	13.7	577	7,904	14,113,600	0.56
16	Grand Valley	138.0	1.5	1,466	2,199	5,703,500	0.38
GILPIN							
RE-1	Gilpin County	47.2	.5	1,811	905	1,759,280	0.51
GRAND COUNTY							
1 Jt	West Grand	396.6	4.3	547	2,352	6,170,770	0.38
RE-2	East Grand	677.0	7.4	594	4,395	11,591.745	0.37

Table XII
(Continued)

County and District	(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additiona Mill Lev Required
GUNNISON						
RE-1J Gunnison Watershed	1,366.0	14.9	$ 452	6,734	$ 15,434,400	0.43
HINSDALE						
RE-1 Lake City	13.4	.1	2,687	268	2,099,680	0.12
HUERFANO						
RE-1 Walsenburg	1,118.1	12.2	284	3,464	9,945,635	0.34
RE-2 La Veta	187.7	2.0	549	1,098	2,723,575	0.40
JACKSON						
R-1 North Park	424.1	4.6	564	2,594	9,206,645	0.28
JEFFERSON						
R-1 Jefferson County	59,340.3	650.9	411	267,519	450,516,220	0.59
KIOWA						
RE-1 Eads	361.7	3.9	811	3,162	9,116,123	0.34
RE-2 Plainview	158.8	1.7	1,050	1,785	6,668,457	0.26
KIT CARSON						
R-1 Flagler	269.2	2.9	553	1,603	3,465,970	0.46
R-2 Siebert	140.8	1.5	745	1,117	2,352,147	0.47
R-3 Vona	86.7	.9	932	838	1,971,729	0.42
R-4 Stratton	311.7	3.4	527	1,791	3,658,949	0.48
R-5 Bethune	103.0	1.1	910	1,001	2,307,422	0.43
RE-6J Burlington	1,014.0	11.1	464	5,150	12,611,509	0.40
LAKE						
R-1 Leadville	2,230.0	24.4	653	15,933	44,544,270	0.35

Table XII
(Continued)

County and District		(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
LA PLATA							
9-R	Durango	3,568.6	39.1	$ 392	15,327	$ 33,946,845	0.45
10-Jt	Bayfield	386.0	4.2	258	1,083	3,835,685	0.28
11-Jt	Ignacio	920.0	10.0	177	1,770	7,786,815	0.22
LARIMER							
R-1	Poudre	11,182.4	12.2	495	6,039	100,462,150	0.06
R-2J	Thompson	5,799.7	6.3	363	2,286	50,395,280	0.04
R-3	Estes Park	791.6	8.6	842	7,241	16,200,370	0.44
LAS ANIMAS							
1	Trinidad	2,227.3	24.4	182	4,440	10,931,820	0.40
R-2	Primero	262.8	2.8	660	1,848	5,099,580	0.36
RE-3	Hoehne	312.3	3.4	507	1,723	5,501,870	0.31
RE-6	Aguilar	233.5	2.5	364	910	2,674,340	0.34
R-82	Branson	73.0	.8	916	732	2,206,400	0.33
R-88	Kim	140.7	1.5	1,016	1,524	4,304,370	0.35
LINCOLN							
RE-1	Hugo	259.6	2.8	611	1,710	5,358,140	0.31
RE-4J	Limon	576.7	6.3	359	2,261	6,647,111	0.34
RE-13	Genoa	116.8	1.2	842	1,010	2,066,115	0.48
RE-23	Karval	104.3	1.1	637	700	2,982,810	0.23
RE-31	Arriba	124.3	1.3	877	1,140	2,964,110	0.38
LOGAN							
RE-1	Valley	3,887.0	42.6	520	22,152	45,197,508	0.49
RE-3	Frenchman	291.0	3.1	480	1,488	4,761,521	0.31
RE-4	Buffalo	315.2	3.4	593	2,016	5,470,550	0.36
RE-5	Plateau	166.5	1.8	1,077	1,938	6,538,017	0.29
MESA							
49Jt	DeBeque	115.9	1.2	1,518	1,821	8,108,757	0.22
50	Plateau Valley	278.7	3.0	585	1,755	5,493,983	0.31
51	Mesa Valley	12,287.2	134.7	377	50,781	102,819,712	0.49

Table XII
(Continued)

	County and District	(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
MINERAL							
1	Creede	172.0	1.8	$ 645	1,161	$ 2,720,180	0.42
MOFFAT							
RE-1	Moffat County	1,752.0	19.2	491	9,427	26,503,790	0.35
MONTEZUMA							
RE-1	Cortez	2,734.7	29.9	286	8,551	18,709,680	0.45
RE-4A	Dolores	571.2	6.2	219	1,357	3,612,085	0.37
RE-6	Mancos	402.2	4.4	237	1,042	2,565,340	0.40
MONTROSE							
RE-1J	Montrose	3,908.2	42.8	309	13,225	26,164,105	0.50
RE-2	West End	1,071.5	11.7	406	4,750	9,591,820	0.49
MORGAN							
RE-2J	Brush	1,468.2	16.1	426	6,858	15,490,250	0.44
RE-3	Fort Morgan	3,167.5	34.7	504	17,488	31,885,000	0.54
RE-20	Weldon Valley	188.1	2.0	804	1,608	3,130,250	0.51
RE-50	Wiggins	523.6	5.7	567	3,231	6,971,170	0.46
OTERO							
R-1	La Junta	2,535.2	27.8	308	8,562	16,113,938	0.53
R-2	Rocky Ford	2,054.9	22.5	262	5,895	15,475,795	0.38
3-J	Manzanola	345.1	3.7	260	962	2,043,684	0.47
R-4J	Fowler	685.7	7.5	363	2,722	6,315,332	0.43
31	Cheraw	252.4	2.7	349	942	2,091,757	0.45
33	Swink	365.4	4.0	321	1,284	2,632,288	0.48
OURAY							
R-1	Ouray	201.1	2.2	556	1,223	2,836,790	0.43
R-2	Ridgway	156.0	1.7	384	652	2,066,425	0.31

Table XII
(Continued)

County and District		(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
PARK							
1	Platte Canyon	247.8	2.7	$ 578	1,560	$ 3,298,780	0.47
RE-2	Park County	198.0	2.1	1,275	2,677	6,775,790	0.39
PHILLIPS							
RE-1J	Holyoke	669.5	7.3	698	5,095	13,267,080	0.38
RE-2J	Haxtun	414.0	4.5	794	3,573	8,031,923	0.44
PITKIN							
1-RE	Aspen	1,055.0	11.5	812	9,338	37,989,430	0.24
PROWERS							
RE-1	Granada	451.0	4.9	410	2,009	5,004,599	0.40
RE-2	Lamar	2,225.4	24,4	301	7,344	17,825,896	0.41
RE-3	Holly	544.6	5.9	485	2,861	6,363,992	0.44
RE-13Jt	Wiley Cons.	290.7	3.1	417	1,292	3,113,573	0.41
PUEBLO COUNTY							
60	City	24,152.2	264.9	257	68,079	166,090,615	0.40
70	Rural	3,853.8	42.2	326	13,757	26,224,851	0.52
RIO BLANCO							
RE-1	Meeker	606.7	6.6	740	4,884	15,886,914	0.30
RE-4	Rangely	643.2	7.0	1,031	7,217	47,473,961	0.15
RIO GRANDE							
C-7	Del Norte	792.7	8.6	316	2,717	6,502,140	0.41
C-8	Monte Vista	1,630.3	17.8	258	4,592	11,089,365	0.41
RE-33J	Sargent	417.6	4.5	634	2,853	6,630,000	0.43

Table XII
(Continued)

County and District	(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
ROUTT						
RE-1 Hayden	317.6	3.4	$ 840	2,856	$ 10,367,880	0.27
RE-2 Steamboat Springs	947.0	10.3	470	4,841	10,613,000	0.45
RE-3J South Routt	366.8	4.0	653	2,612	5,736,325	0.45
SAGUACHE						
RE-1 Mountain Valley	267.2	2.9	487	1,412	3,190,840	0.44
2 Moffat	65.7	.7	191	133	1,656,530	0.08
26 Jt Center Cons.	807.2	8.8	353	3,106	7,096,650	0.43
SAN JUAN						
1 San Juan County	213.2	2.3	680	1,564	3,179,180	0.49
SAN MIGUEL						
R-1 Telluride	204.9	2.2	670	1,474	4,664,300	0.31
R-2Jt Norwood	324.9	3.5	467	1,634	3,476,390	0.47
18 Egnar	74.0	.8	756	604	1,513,440	0.39
SEDGWICK						
RE-1 Julesburg	518.6	5.6	715	4,004	7,740,790	0.51
RE-3 Platte Valley	374.1	4.1	799	3,275	7,838,220	0.41
SUMMIT						
RE-1 Summit County	571.0	6.2	715	4,433	11,459,950	0.38
TELLER						
RE-1 Cripple Creek-Victor	166.6	1.8	919	1,654	2,623,550	0.63
RE-2 Woodland Park	764.5	8.3	311	2,581	4,931,700	0.52

Table XII
(Continued)

County and District		(1) ADAE 1970	(2) Est. No. Children In Need of Services[b]	(3) Total General Fund Property Tax Revenue/ADAE	(4) Potential Cost to School District	(5) Assessed Valuation 1969*	(6) Additional Mill Levy Required
WASHINGTON							
R-1	Akron	628.4	6.8	610	4,148	$ 10,452,605	0.39
R-2	Arickaree	251.6	2.7	801	2,162	7,536,635	0.28
R-3	Otis	237.3	2.6	718	1,866	4,484,335	0.41
101	Lone Star	53.3	.5	1,620	810	2,857,870	0.28
R-104	Woodlin	165.8	1.8	1,401	2,521	12,645,545	0.19
WELD							
RE-1	Valley-Gilcrest	1,420.0	15.5	334	5,177	12,349,090	0.41
RE-2	Eaton	1,191.8	13.0	466	6,058	21,129,230	0.28
RE-3J	Keenesburg	1,317.2	14.4	352	5,068	14,499,040	0.34
RE-4	Windsor	896.0	9.8	452	4,429	10,399,390	0.42
RE-5J	Johnstown	846.7	9.2	543	4,995	10,051,770	0.49
6	Greeley	9,290.0	101.9	393	40,046	72,044,800	0.55
RE-7	Platte Valley	830.2	9.1	477	4,340	8,776,700	0.49
RE-8	Fort Lupton	1,554.6	17.0	246	4,182	9,669,260	0.43
RE-9	Highland	927.6	10.1	756	7,635	13,310,100	0.57
R-10J	Briggsdale	86.5	.9	1,240	1,116	2,091,920	0.53
RE-11J	Prairie	170.2	1.8	1,129	2,032	5,981,135	0.33
RE-12	Pawnee	165.5	1.8	587	1,056	3,770,800	0.28
YUMA							
R-J-1	West Yuma	1,087.6	11.9	657	7,818	15,080,079	0.51
R-J-2	East Yuma	952.0	10.4	642	6,676	15,005,985	0.44
Total or average					$2,265,598		0.40

a/ School District ADAE, property tax revenue, and assessed valuation prepared by Colorado Association of School Boards.

b/ A factor of .01097 was applied times the ADAE of each school district to arrive at the possible number of children in need of community center services for the trainable mentally retarded and seriously handicapped. The factor is based on an estimated 5,500 enrollment at community centers, which represents a maximum level of service.

* The 1969 Assessed Valuations are the basis for taxes collected in 1970.

Additional Items Concerning Mental Retardation

Community Placement Program

With the growth in the philosophy that, whenever possible, mentally retarded persons should remain in a community setting and with the accompanying growth of community programs for the mentally retarded, there has been a concerted effort to reduce the population at the state's three training homes for the mentally retarded. Retarded persons who were formerly in institutions are now being placed in facilities in the community. The program designed to accomplish this placement is administered jointly by the Department of Institutions and the Department of Social Services. The Department of Social Services was included in the program in order to utilize federal funds available to that agency for the purpose of placement. Social Services has federal funds available for the placement of retardates who qualify for Aid to the Needy Disabled and other categories of assistance. Even though these federal funds are helpful in the placement of some of the retardates, it has been argued that the dual administration of the program leads to confusion and overlapping. One of the problems associated with the Department of Social Services' involvement in the placement program is that funds have not been made available to county welfare departments to care for the mentally retarded.

The Community Placement Program has not been recognized statutorily; rather, the program has been funded through a footnote in the Appropriations Bill in the appropriation to the Department of Social Services. For example, the 1970 appropriation to the Department of Social Services contained a $323,920 item for the Mental Retardation Placement Program. The footnote that accompanied this item reads as follows:

> Department of Social Services - Division of Public Welfare - This appropriation is intended to continue the Department of Institution's "Program Plan for the Mentally Retarded" facilitating substantial reduction of the current populations of the three institutions for the retarded through an aggressive community placement plan administered jointly by the Department of Institutions and the Department of Social Services. Persons so placed under this plan will remain under the supervision of the institution from whence they have come, or of the Division of Mental Retardation of the Department of Institutions.[28]

28/ Chapter 15, 1970 Session Laws, Footnote 34, page 65.

The Department of Social Services reports that from April 1, 1969, to March 1, 1970, 215 retardates had been placed, 165 adults and 50 children. As of June, 1970, none of those who have been placed have been returned to the institutions. For fiscal year 1969-70 the Community Placement Program received state funds totaling $244,502. In addition, $82,532 was available from the counties, and $166,865 from the federal government bringing the total amount to $493,899. With this amount an anticipated 51 children and 381 adult mental retardates were expected to be placed. For fiscal year 1970-71 it is anticipated that 400 retardates, 122 children and 278 adults, will be placed, and $685,995 local, state, and federal dollars will be available for the programs.

The persons who administer the Community Placement Program have pointed out several problems in the placement programs. One problem is finding proper facilities in which the retardates can be placed and that will meet Department of Health standards. A second problem is insuring that casework services are provided once the retardate has been placed. It has been suggested that a program of protective services would help to alleviate the latter problem.

Licensing of Residential Care Facilities

The Department of Health is responsible for the licensing of residential care facilities into which retardates are placed. Two problems have arisen in the area of licensing: a) the Department of Health's standards are so high that many facilities are unable to meet them and hence there is a shortage of facilities available for retardates waiting to be placed in the community; b) the Department of Health does not have enough staff to inspect facilities for the mentally retarded when these facilities are made available. Consequently, there may be retardates waiting to be placed and facilities available but no placement can occur because the facilities have not been licensed.

Residential care facilities have been classified as health care facilities by the Board of Health and are hence required to be licensed by the Department of Health. The rules and regulations of the Board of Health define a "residential care facility" as "an establishment operated and maintained to provide residential accommodations, personal services, and social care to individuals who are not related to the licensee /owner or operator/ and who because of impaired capacity for self care elect or require protective living accommodations but who do not have an illness, injury, or disability for which regular medical care and 24-hour nursing services are required."

Even private homes which are willing to take in one or two retarded persons and are in essence foster homes are required

to be licensed as residential care facilities in order to qualify as approved facilities under the Community Placement Program. They are required to have such things as "an organized food service" in which menus must be planned at least one week in advance, a "mass casualty program", etc. Many private homes have difficulty complying with some of the standards.

A number of questions and suggestions have been raised regarding the licensing of residential facilities for the mentally retarded. If the individuals in residential care facilities do not require regular medical attention, are these facilities in fact "health care facilities"? Could they be licensed by the Department of Social Services as are day care centers, foster homes, etc.? If the Department of Health retains the responsibility for licensing these facilities, is there a need for more licensing personnel to be added to the staff of the Department of Health to expedite the process of approving facilities for the mentally retarded? Is it possible for the Department of Health to relax the licensing standards or to allow probationary periods or provisional licenses for facilities which cannot meet standards?

Protective Services

A very serious problem faces the mental retardate who leaves the institution for placement in the community. Most of these people were committed to the institution years ago and were adjudicated incompetent and hence lost all of their civil rights. The director of the institution acts as their legal guardian while they are institutionalized and this condition continues for a year after their release and then terminates. After this time, the retardate has no rights and no legal guardian to act in his behalf. The majority of retardates who are placed in the community are recipients of Aid to the Needy Disabled (AND) and consequently receive some assistance from county welfare workers. However, the county welfare department has no authority to act as the legal guardian for the retarded person.

This is a very serious problem at the present time but will increase as adult retardates continue to be removed from the institutions and placed in the community. It has been suggested that a program of protective services be established whereby the Department of Social Services could be appointed the legal guardian of the retardates who are being placed in the community and are without legal rights.

Other situations exist where a program of protective services might be warranted. For example, there are adult retarded persons in the community who live with family members, have never been institutionalized and hence have never been adjudicated incompetent. Once the family of such a retarded person is no longer able to care for him, he may need some kind of protec-

tion and supervision. Under current law, the only way this person could receive the guardianship he requires is by a court adjudicating him incompetent and assigning him a legal guardian. Advocates of protective services legislation believe that the courts should be able to establish a ward-protector relation between the Department of Social Services and the retarded person without depriving the person of all his legal rights.

Finally, there are retarded persons who may not need a legal guardian to supervise their affairs but they may require some assistance in finding employment, locating housing, seeking medical help, etc. These persons may not necessarily be recipients of welfare but could benefit from the assistance of a caseworker assigned to look after them. Perhaps a mechanism should be devised whereby a retarded person or someone acting in his behalf could voluntarily seek the assistance of the Department of Social Services. Such a voluntary ward-protector relationship would not require a court order and could be terminated at any time from either side.

SPECIAL EDUCATION

History of Special Education Laws in Colorado

1953 Law for the Education of Handicapped Children. In 1953, the General Assembly passed a law providing reimbursement to local school districts for special education programs for the mentally and physically handicapped. The law allowed state reimbursement to local districts based on the excess cost of special education and also provided for up to 80 percent reimbursement for speech correctionists and other approved supplementary teaching services. The 1953 law remained in effect, with no changes, until 1965 when the new "Handicapped Children Education Act" was passed.

1965 Handicapped Children Education Act. The 1965 act, 123-22-1 et. seq. C.R.S. 1963 (1965 Supp.), as amended, provides that six major categories of handicapped children qualify for special education: 1) educationally handicapped (children who are perceptually or emotionally handicapped); 2) educable mentally handicapped; 3) aurally handicapped; 4) visually handicapped; 5) crippled (this category includes children with all kinds of health problems); and 6) speech handicapped. For the first two categories, the law limits reimbursable expenditures to programs for children between the ages of five and 21. For the remaining categories, state reimbursement funds are available for children between the ages of three and 21. The law also provides for the instruction of children who are homebound or hospitalized, and for the placement of a child in a foster home or transportation costs when the child goes to a special education program in a district other than his own.

Reimbursement Schedules. The 1965 law provides that school districts which operate state approved special educational programs for the above mentioned categories shall be entitled to reimbursement for: 1) eighty percent of the compensation of approved personnel; 2) one-half of the costs of special transportation; and 3) the full amount of the cost of maintenance of a child in a licensed foster home, not to exceed eight hundred dollars per school year. In 1969, the General Assembly also approved 80 percent state reimbursement for the cost of home-to-school equipment used for instruction of homebound or hospitalized students.

Approved Personnel. Approved personnel salaries which are reimbursable include the following: special classroom teachers, special itinerant teachers, directors and supervisors of special education and speech correctionists. The state may also provide 80 percent reimbursement for the costs of consultation and evaluation by psychiatrists, psychologists, and social workers.

Growth of Special Education

Since 1953, special education programs have expanded considerably, both in terms of the numbers of students served and the amounts of state appropriations for reimbursement purposes. In 1953, the General Assembly appropriated $200,000 for the reimbursement of special education; this amount has increased to the $5,000,000 which was appropriated for expenditures in academic year 1969-70. The number of children enrolled in special education courses has also increased. The total enrollment in special education classes in 1953 was 3,535 or 1.3 percent of the total school enrollment. In academic year 1968-69, 29,180 students were enrolled in special education programs. Table XIII shows the total number of students, teachers, and districts in each of the several programs for the period 1957-1969. Also shown is the appropriation of state funds for each of these years, 80 percent of the actual costs for providing services, and the percentage of the actual claim reimbursed by state funds.

As the table indicates, the largest number of pupils are enrolled in the speech correction program -- 17,127 in 1969 -- followed by those students in classes for the educable mentally handicapped -- 7,116 -- and the educationally handicapped -- 3,160. The teacher-student ratios vary from program to program and, in some instances, differ markedly from district to district within a program. The largest ratio of teachers to students is in the speech correction program, while the smallest ratio is in the home instruction program for the educationally handicapped.

The total enrollment figure for special education classes epresents 5.6 percent of the total school enrollment for 1968-69. However, the Division of Special Education Services, State Department of Education, estimates that approximately 12 percent of the total number of children enrolled in schools have some type of handicap which would qualify them for special education. Consequently, there are still a number of handicapped students who are not receiving special instruction. Using the Division's 12 percent figure, 33,086 school-age children or an additional six percent of the total enrollment in 1968-69 could benefit from special education programs. Some of these pupils are on waiting lists for school district programs.

Sample Expenditures in Special Education

Table XIV shows by program the total costs of the various special education programs, and the maximum percentage of those costs that the state will fund: 80 percent of the costs in all cases except for transportation, which is funded at 50 percent of the costs and foster home maintenance which is funded 100 percent of the costs. The total amount of the claims submitted for 1968-1969 is $6,215,008. The state appropriated $4,000,000 for

Table XIII

SPECIAL EDUCATION PROGRAMS

Fiscal Year	Moneys: Legislative Appropriations	Moneys: Claims Submitted Representing 80% of Actual Costs of Services	Moneys: Percent of Claim Funded	Total Number of Students, Teachers, and Districts in each Program: Aurally Handicapped Children*	Teachers	Districts	Educable Mentally Handicapped Children	Teachers	Districts	Educationally Handicapped Children*	Teachers	Districts	Physically Handicapped Children**	Teachers**	Districts**	Speech Correction Students	Teachers	Districts	Visually Handicapped Children*	Teachers	Districts	Home-Hospital Children	Specialty Teachers	Districts	Student Total***	Teacher Total	Percent of Total School Population Enrolled in Special Education
1957	$ 400,000	$ 512,569	76.0%				1,014						529			3,750			140			432			5,725		1.84%
1958	400,000	568,357	67.0				1,320						539			5,084						423			7,366		2.24
1959	424,000	654,322	64.8				1,673						570			6,064						451			8,758		2.53
1960	475,000	771,977	61.6				2,048						626			7,397						491			10,562		2.90
1961	650,000	841,578	77.2				2,469						636			8,333						505			11,943		3.04
1962	800,000	1,431,600	55.8				2,981						709			10,108						496			14,294		3.44
1963	1,200,000	1,927,147	62.2				3,574						731			10,884						477			15,666		3.57
1964	1,200,000	2,230,601	53.7				3,711						662			13,377						572			18,322		3.98
1965	1,300,000	2,473,024	52.5				4,079	296					606	68		13,961	110					595			19,241	474	4.04
1966	1,884,000	2,699,803	69.7	310	32	7	5,227	332	39	103	13	6	396	25	5	14,188	126	36	140	14	5	635	8	0	20,999	542	4.31
1967	2,705,000	3,969,448	68.1	340	37	15	5,404	386	49	1,186	64	16	419	27	5	14,504	131	48	117	13	5	738	9	3	22,708	667	4.56
1968	3,000,000	5,036,606	59.5	355	41	15	6,378	431	60	2,801	134	40	408	24	5	14,758	149	57	155	12	5	792	11	4	25,617	802	5.03
1969	4,000,000	6,215,008	64.3	392	43	15	7,116	478	75	3,160	178	53	365	26	11	17,127	160	62	164	15	7	848	11	55	29,172	900	5.66
1970	5,000,000	8,000,000(est)																									
1971	?	9,159,215(est)																									

Source: Compiled by Legislative Council staff from a State Department of Education statistical compilation of November, 1969.

* In 1965, C.R.S. 123-22-1 et seq., provided enabling legislation for the funding of special education for those children aurally, visually and educationally handicapped. Prior to 1965 the aurally and visually handicapped children were classified with crippled children in the physically handicapped area. The educationally handicapped category was created with the 1965 legislation.

** There are no figures available for the number of teachers teaching the physically handicapped children or the number of districts offering programs prior to 1965.

*** These totals do not include children provided with foster home maintenance; however, this sum is small -- in 1968-69, the number totalled eight children.

Table XIV

STATE REIMBURSEMENT FOR
SPECIAL EDUCATION SERVICES

SCHOOL YEAR JULY 1, 1968
THROUGH JUNE 30, 1969

Program, Personnel Or Service	Total Cost of Programs[1]	Maximum Claim for State Reimbursement[2]	Actual Reimbursement on the Basis of 64.3% of Maximum Claim[1]	% of Actual Reimbursement[3]
Directors	$ 356,121	$ 284,897	$ 183,189	4.5%
Assistant Directors	54,576	43,661	28,074	.7
Supervisors	106,319	85,055	54,690	1.2
Aurally Handicapped Teachers	325,549	260,439	167,462	4.1
Educable Mentally Handicapped Teachers	3,333,981	2,667,184	1,714,999	42.8
Educationally Handicapped Teachers	1,239,904	991,923	637,806	16.9
Physically Handicapped Teachers	213,097	170,471	109,617	2.7
Speech Correctionists	1,063,066	850,453	546,841	13.6
Visually Handicapped Teachers	123,567	98,854	63,563	1.5
Specialty Teachers	90,660	72,528	46,635	1.1
Home Instruction - Educationally	30,697	24,557	15,790	.3
Home/Hospital - Physically Hand.	186,920	149,536	96,151	2.4
Psychologists	346,518	277,214	178,249	4.5
Social Workers	97,848	78,279	50,333	1.2
Psychiatrists	16,493	13,194	8,484	.2
Transportation	281,939	140,969[4]	90,643	2.2
Foster Home Maintenance	5,780	5,780[5]	5,780	.1
	$7,873,043	$6,215,008	$3,998,314	100.0%

1/ The total amount of claim and the pro rated amount were calculated by the Legislative Council staff from figures obtained from Mr. Chuck Reynolds, Principal Clerk, Division of Special Education Services, State Department of Education.

2/ Dollar amounts of claims reimbursable up to the maximum of the statutory provisions provided by Mr. Chuck Reynolds, Principal Clerk, Division of Special Education Services, State Department of Education.

3/ Percentages calculated by Legislative Council staff.

4/ The maximum claim for transportation costs is 50 percent of total expenditures.

5/ The state reimburses school districts for 100 percent of foster home care.

special education in 1968-69. Thus, the claims were pro rated at approximately 64 percent of the claim, except for foster home maintenance which was fully funded.

The table indicates that the largest share of the expenditures, 43 percent, are for the educable mentally handicapped program; next, the educationally handicapped program (16 percent) the next large percentage of expenditure of funds is for speech correctionists (14 percent). These are the three largest programs in terms of expenditures.

Federal Funds Available to Colorado for Special Education

Several sources of funding for special education programs are available to Colorado from the federal government. The major source is an annual appropriation to the state under the provisions of Title VI of the Elementary and Secondary Education Act. These monies are used to expand and upgrade existing special education programs for handicapped children. For school year 1968-69, Colorado received $285,258 Title VI monies. Public Law 88-164, the act that provided the major impetus for the development of community mental health and retardation facilities, also makes federal monies available for inservice training of special education personnel. Last year Colorado received $73,135 for this purpose. Colorado also receives an annual allocation from the federal government for the purpose of purchasing books and other teaching materials for the blind from the American Printing House; last year Colorado's allotment was $11,000.

In addition to annual appropriations and grants to the state, the federal government makes special grants for projects which they approve. Colorado has recently received grants for three projects. Each of the projects was funded for a 13 month period, June 1, 1969 to June 30, 1970. The first grant of $36,260 was for Colorado's contribution in the planning of a five-state deaf and blind project. The two other projects were funded through EPDA (Education Professionals Development Act) grants. One grant of $64,324 was for the inservice training of social workers for work with the handicapped. The second grant, $69,676, was for on-the-job training of school psychologists.29/

Federal funds pay the salaries of eight of the professional employees on the state staff for special education. Three positions are funded through Title VI monies. Public Law 88-164 funds pay the salary of the state staff consultant for education and inservice training of personnel. The remaining non-state positions are salaried through grants from the U.S. Office of Education.

29/ Dollar amounts for federal funds provided by Chuck Reynolds, Principal Clerk, Division of Special Education Services, State Department of Education.

A final source of federal funds for handicapped programs is under the provisions of Title I of the Elementary and Secondary Education Act. Title I moneys are specifically earmarked for educationally deprived children. Because many handicapped children are also "deprived" and therefor eligible under Title I guidelines, school authorities are using these funds to supplement local and state monies to initiate and maintain programs for the handicapped. These moneys have been useful in rural areas where a few underprivileged children qualify an entire school for funds. In larger towns, only schools in deprived areas are eligible.

Duties of the State Board of Education

The State Board of Education is charged with responsibility for the administration of the Handicapped Children Education Act. The Board is authorized to adopt rules and regulations for the administration of the article. In addition, the Board prescribes minimum physical facilities required by the special education programs, determines the diagnostic criteria for enrollment in programs, prescribes minimum and maximum enrollments, and requires that all special program personnel hold a valid certificate or a letter of authorization appropriately endorsed.30/

State Department Staff. In order to carry out the legislative directive to administer the handicapped education article, the State Board created a Special Education Services Division. The Division currently has a professional staff of twelve. In addition to the Division director, there are a total of ten specialty consultants for the following areas: programs for the educationally handicapped, mentally handicapped programs, aurally and speech handicapped programs, physically and visually handicapped programs, social work, school psychology, instructional media (position currently unfilled), education and inservice training of special education personnel, Title VI, Elementary and Secondary Education Act, grant programs, and for the Regional Center for Services for Deaf-Blind Children. Of the twelve state positions, only four are positions for which the state pays; the other eight positions are salaried with federal monies.

30/ Section 123-22-5 and 6, C.R.S. 1963 (1965 Supp.).

Scope and Standards for Programs for the Several Categories of Handicap[31]

Educationally Handicapped Children

Definition. By law, "educationally handicapped children" means those persons between the ages of five and twenty-one who are emotionally handicapped or perceptually handicapped, or both, and who require special education programs. The educationally handicapped child may be further described as one whose behavior manifests itself in such a manner that it is interfering with the child's education process or the education process of others. In most instances, there is a significant discrepancy between apparent ability and the actual level of functioning.

Determination of Handicap. The determination of the educational handicap of a child is made by a special committee designated by the local board of education. In most instances the committee consists of a psychiatrist, psychologist, social worker, and school administrator. Other members may be added to the committee at the discretion of the local district. The permission of the parent or guardian of the child must be obtained before either an individual study is made of the child or the committee makes a determination of the existence of an educational handicap.

Standards of Eligibility. A child whose basic handicap is determined to be mental or physical cannot be included in a program for the educationally handicapped. However, a child who is functioning at the level of a mentally handicapped child, but is not truly mentally handicapped, and could benefit from remedial instruction may be classified as educationally handicapped. Numerous types of problems may be identified in educationally handicapped children. However, many students are found to suffer from one or more of four general interrelated problems:

1) Poor self concept -- a lack of self esteem and self reliance.
2) Reading difficulties -- lack of phonetic skills, deficient reading vocabulary, poor comprehension and oral fluency problems.

31/ Much of the material in this section was derived from a State Department of Education publication entitled "Administrative Procedures for Special Education", 1965, Chapter 1, pp. 1-16. The statistical information was supplied by the Division of Special Education Services and is included in total in Table XIII, on page 97.

3) Perceptual-motor disorders.
4) Language development deficiencies -- poor listening skills, lack of language comprehension, and inadequate expressive language skills.

These handicaps are often related to insufficient language experience opportunities in the home environment.

Program. Local school districts may provide instruction for educationally handicapped children in a number of ways. The school may provide classroom instruction in small classrooms with a membership of only five to ten pupils. The teacher in charge holds a certificate or endorsement as a teacher of the educationally handicapped and must have received special training in order to qualify as a special education teacher. The committee which evaluated the child recommends the number of periods the child should attend special classes. Some smaller local districts combine to hire an itinerant teacher who travels from school to school and works with children singly or in small groups for one or more periods. And finally, when it appears that the needs of an educationally handicapped child cannot be met in any other way, the school district may provide for the home instruction of a child.

Specific programs for the educationally handicapped may vary greatly from district to district. However, in all instances, the programs are designed to return the child to the regular classroom as quickly as possible. A common procedure is for the child to attend a resource room as his individual needs demand. There a special teacher provides instruction designed to help the child overcome his learning problem.

Scope of the Programs. In academic year 1968-69, 53 school districts provided special education programs for educationally handicapped students. A total of 3,160 students were enrolled in the programs. This represents a significant increase over the 103 students who were in programs for the educationally handicapped in 1965-66, the first year the General Assembly provided reimbursement to local districts for educationally handicapped programs. However, according to Department of Education statistics, the 1968-69 program falls short of reaching all the children needing special instruction. The division estimates that three percent of all the children enrolled in school are educationally handicapped. Applying this percentage to the 1968-69 enrollment, 15,730 children could have benefitted from special instruction.

Educable Mentally Handicapped

Definition. "Educable mentally handicapped children" are those persons between the ages of five and twenty-one years whose intellectual development renders them incapable of being practi-

cally and efficiently educated by ordinary classroom instruction in the public schools, but who nonetheless possess the ability to learn and may reasonably be expected to benefit from special programs.

Determination of Handicap. The determination of the mental handicap of a child is made by individual examination conducted by a psychologist with the consent of the parent or guardian of the child. In the event that the parents or guardian of the child disagree with the determination of the psychologist or the placement of the child in a special program, they may refer the child to a psychologist of their own choice, and at their own expense, and submit his evaluation to the local board of education. The board of education has the ultimate right of placement of children attending the public schools within its jurisdiction.

Standards of Eligibility. The State Board of Education established an intelligence quotient between 50 and 80 as the standard upon which a child may usually be enrolled in special education classes for the mentally handicapped. However, other pertinent factors, such as social and emotional development, may be considered in determining the need for special education, or for deciding that the applicant has such extreme mental deficiency that he is not eligible for special education.

Program. The minimum and maximum membership of special education classes for the mentally handicapped are determined by the age range of those enrolled. However, at no time does class membership exceed fifteen. In many cases, the classes for the educable mentally retarded are designed much differently from the curriculum in regular classes. The classes are more vocationally oriented than academic. In addition, various districts are attempting to develop sequential, functional curricula which provide a meaningful integrated education for mentally handicapped students from elementary to high school.

More school districts, 75 in number, provide special programs for mentally handicapped students than any other type of special education program. In academic year 1968-69 a total of 7,116 children were enrolled in special education programs in the state's public schools. This figure represents a substantial growth over the past ten years; in 1959-60, only 2,048 mentally handicapped students received instruction in special classes. The number of teachers involved in special programs for the mentally handicapped in 1968-69 was 478.

Physically Handicapped Children

Aurally Handicapped. Deaf and hard-of-hearing children are those who, because of a deficiency in the hearing threshold level, even with the help of special aids, are unable to participate in or benefit from the classroom programs regularly pro-

vided. Enrollment in a special education program is recommended by a physician licensed to practice medicine in Colorado. The objective of special instruction of the aurally handicapped is to provide the child with a communication system which will enable him to develop subject matter skills in addition to the acquisition of a capability for social communication.

Children are provided instruction in the use of simplified sound, lip reading and speech, in addition to the regular curricular program. In at least one district program a combined communication approach is available involving manual and sign language as well as the techniques mentioned above. In 1968-69, fifteen school districts provided special programs for aurally handicapped children. The number of pupils involved in the programs was 392 and the number of teachers 43.

Physically Handicapped -- Crippled. The program for the physically handicapped in Colorado's public schools is designed to provide specialized school facilities or homebound instruction for children who, because of orthopedic, infectious, cariopathic, cerebral palsy, or other conditions are unable to participate in or benefit from the classroom program regularly provided. The basic curriculum does not differ but the provision of appropriate physical facilities, equipment and materials is important. The objective of the program is to provide the necessary conditions for a child to achieve his educational potential within the framework of his physical limitations. In 1968-69, 365 students with physical handicaps of the kind described above received instruction from 26 special teachers in eleven school districts in Colorado.

Visually Handicapped. The educational program for the visually handicapped in the public schools of Colorado is designed to provide appropriate facilities, equipment and instruction for a child depending on the type and extent of his visual problem. The overall objective of the program is to provide instruction, utilizing appropriate materials and equipment, that will allow the child to remain in the regular classroom. Instruction includes the developing of independence and mobility skills, the learning of braille, or the utilization of existing vision. In 1968-69, seven school districts offered special instruction for 164 visually handicapped children.

Speech Handicapped Children. A final group of children for whom special instruction is available are children with speech defects. Students between the ages of three and twenty-one whose speech is defective may be enrolled in speech correction programs. The board has defined that speech is defective when it deviates so far from the speech of other people that it calls attention to itself, interferes with communication, or causes its possessor to be maladjusted. A speech correctionist determines who is eligible to receive speech correction. Services are available to children from kindergarten through grade 12. The objective of the program

is to identify and correct the problem as quickly as possible before it interferes with the child's total school adjustment. A speech correctionist normally provides correctional services for not more than 70 to 90 speech defective children on a bi-weekly basis in 30 to 35 minute sessions. During the last school year 17,127 children in 62 school districts received speech correction services.

Specially Designed Programs For Handicapped Students

Work-Study Programs

The work-experience programs for the visually, the aurally, the educationally, and the educable mentally handicapped child and for the crippled are based on the realization that many will not go beyond high school. The programs are designed to prepare the student to successfully pursue a job. To date, 35 school districts have initiated work-study programs for handicapped students. Programs may differ greatly from one district to another, but the basic objective in all the programs is the same -- to prepare the student to enter the world of work with some necessary skills and attitudes. Some districts provide only high school level work-study programs; however, the type of program that the Division of Special Education Services encourages districts to set up is one that follows the handicapped child from grades one through twelve. A twelve year program might be organized along the lines of the program described below.

Proposed Work-Study Program. At the elementary level, units on social and occupational living and certain fundamental academic areas would be developed and emphasized. The goal at this level would be to expose each student to concepts of the work world and to develop work attitudes. The basic skills taught at the junior high level should be kept as functional as possible. Students would receive some work orientation at this level through placement in in-school work station assignments. Generally, students would work at their work stations for a portion of the day. In addition, the teaching of attitudes is important; the teacher should emphasize the importance of work experience, developing ability to follow directions, the necessity for getting along well with fellow employees, social skills, and effective use of time. Students would be evaluated and receive a grade and credit toward graduation.

Emphasis during the first year of high school would be academic. Study areas would be directed toward the realistic problems that students may face when they leave school. However, there would again be opportunity for work experience within the school setting. Students could take one or two elective classes (home economics, industrial arts, etc.). Evaluation of the student is important in order to be able to place him in the right type of job.

During the junior year, the program emphasis would become more occupational in nature. The student would spend one-half of his day in school and the other half in a work-experience job. Special education teachers, parents and other members of the work-study team would cooperatively formulate an occupational plan for each student. During the senior year, the program emphasis should become increasingly occupational in nature. The pupil would be exposed to two or three work-experience jobs -- the last of which will hopefully lead into full-time employment.[32]

Advocates of the work-study programs point to their apparent effectiveness. They believe such programs are an answer for many handicapped young people's needs.

Poudre R-1 School District Work-Study Program. One program which attests to the success of the work-study programs is the program set up in the Poudre R-1 school district. This school district provides for twelve grades of study for the Educable Mentally Handicapped supplemented by a work-study experience during the last two years. During the sophomore year, the students have three or four hours of class each day. They learn how to apply for and keep a job, how to budget money, and how to handle situations related to family living. During this period, they work at the Walter Cooper Memorial Vocational Training Home.

In their junior year, students are required to "live in" at the home for a period of six months and put to use all the skills they have acquired. In short, they are taught to accept group and personal responsibility. Each student earns a salary by working a half day. The student attends school the other half day. The Division of Rehabilitation, Department of Social Services, cooperates in determining each pupil's needs, sets up special work programs during the summer months, and funds the pupils during the period they live in the home.

Graduates of this course are to date all employed; most of them are self supporting.

Cooperative Services

Many schools have small numbers of handicapped students in various categories but not enough to allow them to establish special programs. Some Colorado school districts have solved this problem by joining with other districts to form cooperatives. The Boards of Cooperative Services Act, 123-34-1 et seq. C.R.S. 1963 (1965 Supp.), provides that the boards of education of two or more

32/ Many of these ideas come from an article by Betty Mitchell, Consultant, Division of Special Education Services, on work-study programs in Education Colorado, March 25, 1969.

school districts may establish a board of cooperative services for the purpose of providing cooperative educational service programs. Programs for handicapped children may be considered as part of this concept. Many phases of the special education program lend themselves especially well to cooperation among districts. For example, itinerant programs can be established where special teachers can travel among the several districts in the cooperative, providing services to handicapped children which could not otherwise be offered singly by the districts.

To date, eleven board of cooperative services have established special education programs. Some 68 school districts are benefitting from the programs provided by these eleven boards. Thus, boards make expanded services possible in areas of the state that otherwise would have had little or no services. For example, the San Luis Valley Board sponsors 32 special teachers and speech correctionists who provide services to the handicapped in such locations as Del Norte, Sanford, Sangre de Cristo School at Mosca, and Sierra Grande School near Fort Garland. Three school districts in Routt County, and the school district in Jackson County have formed a cooperative which provides a special education program to the member districts. While the total school enrollment of the four combined districts was approximately 2,000 in 1968-69, the special education staff included speech correctionists, teachers of aurally, visually, educationally, and educable mentally handicapped children, and a school psychologist.

Problems and Questions Relating to Special Education

Question of Responsibility

Should local school districts be responsible for determining the type, scope, direction, and development of special education programs or are these decisions that should be made at the state level and carried out by local school districts under the advice and direction of the state Department of Education? Historically and constitutionally it has been the duty of local school boards to plan program and curriculum. A second fundamental question is whether local school districts should be required to make special education programs available to children in the district or should this decision be optional to the local school districts?

Currently school districts have the option of deciding whether or not to provide special education programs. About half of Colorado's school districts do not have special education programs. Most of these districts are in rural areas where the numbers of handicapped children in each of the several categories are few. One of the ways rural districts can provide programs to their handicapped students is to enter into cooperatives with other districts and establish itinerant or mobile classroom pro-

grams. However, even with cooperatives, many rural school districts still lack the financial resources to establish programs.

According to the Division of Special Education Services, the greatest need is not in the rural areas, however. Instead it is in the population centers where more children should be included in programs. While most of the school districts in the major population centers of the state have established programs for all the categories of handicap, the programs are not extensive enough to serve all the children who qualify for the programs. For example, during one month of the 1967-68 school year, Denver reported that 332 mentally handicapped youngsters alone were on waiting lists for special education classes. These were children who had been tested and evaluated and determined to be eligible for special classes, but for whom programs were not available.

Problems Related to Funding of Special Education

The state currently funds less than 80 percent of costs of special education. While the law allows the state to reimburse, for special education, 80 percent of the cost of salaried personnel and 50 percent of the cost of transportation, actual reimbursement funding has ranged from 69.7 percent in 1965-66, the first year of the new reimbursement schedule, to 59.5 percent in 1967-68. For the other years, reimbursement equalled 68.1 percent of full claims in 1966-67, and 64.3 percent in 1968-69. For school year 1969-70, the General Assembly appropriated $5 million for special education reimbursement. The Department of Education estimates that in 1969-70, school districts will submit claims of $8 million for state reimbursement; thus, the state will be paying 62.5 percent of the total claims.

Each year the General Assembly's appropriation for special education has been less than the school districts' claim for reimbursement, and this has been a point of much criticism. The Joint Budget Committee responds to this criticism by pointing out that it lacks adequate data on which to base its decision as to a suggested level of state funding for special education. One of the problems in the funding of special education programs and personnel is that the state appropriation is based on anticipated enrollment in special education classes since the appropriation is made almost nine months in advance of the school year. Once the academic year is over, the total costs of such programs, personnel, etc., are submitted to the Special Education Services Division. The Division then computes the amount each school district is entitled to according to the statutory provisions for percentages of reimbursement. The claims are then pro rated in proportion to funds available for reimbursement.

If the General Assembly is going to grapple with the matter of funding special education, the following questions may need to be discussed.

1) Information Required in Budget Request. If the state is to continue to reimburse school districts for a share of their efforts in special education, should school districts via the Department of Education provide more meaningful projections on special education expenses For instance, at present the department's budget request is based on a pattern of increase in special education. There are no actual figures on projected enrollments, number of personnel, etc. Additionally, a variety of other funds are available for special education. Federal funds are available to some school districts through the Elementary and Secondary Education Act. Vocational rehabilitation monies are sometimes available and vocational education monies are used in certain work-study programs. Because of all these variables, it is difficult to assess the impact of state funds on special education. What should be the responsibility of local school districts and the Department of Education in making accurate data available to the General Assembly?

2) Program Projections. It is difficult to make projections about the future needs in special education in terms of dollars, manpower, etc., because data on the actual number of children in Colorado who require special education is not available. School districts which have special education programs have spent their time serving those already identified and those school districts without programs have not attempted to identify children with special need because there would be no programs for them anyway. Nevertheless, it seems there is a need to develop some kind of data about special educational needs throughout the state in order to make sound decisions concerning program and budgetary matters.

Is the state willing to undertake the expense of identifying special educational needs of all school-age children in the state which may require state-wide psychological testing and evaluation? Or should school districts be required to identify all the "special education" children in their district?

3) School Foundation Monies for Special Education. Testimony of special education directors from several school districts in the state indicates that in many cases the special education children are not benefitting from the School Foundation money to which they are entitled. Perhaps this results from a misunderstanding of the intent of the special education law. Prior to the enactment of the Handicapped Children's Act of 1965,

which established the present formula for state reimbursement of special education programs, the state reimbursed schools for the "excess costs" of special education beyond the cost of educating a normal child in a regular classroom. Determining excess cost was a time consuming administrative chore. In 1965 the law was amended to provide state reimbursement for 80 percent of the salaries of special education personnel. The figure of 80 percent was decided upon because it was calculated the "excess costs" had averaged near 80 percent.

Was it the intent of the legislation that the state percentage reimbursement was to be the only state money involved in special education or were special education children also to receive their share of the ADA School Foundation monies? If it is the intent of the legislature that these children receive an equal share of the School Foundation monies in addition to reimbursement, does this need to be spelled out in the Foundation Act or the Handicapped Children's Act?

Additional Needs of Special Education

Lack of Qualified Teachers for Special Education Programs. The lack of qualified teachers is a problem in rural districts. Districts in larger towns usually have little trouble finding qualified special education teachers but must pay them more than regular instructors. One solution to the lack of qualified teachers is to encourage regular teachers to take courses to certify them as special education instructors. However, many of these teachers need some kind of incentive to obtain this training. A second way to solve the teacher shortage is to actively recruit from colleges and universities. Again, it has been suggested that it may be necessary to offer students some type of scholarship or financial incentive to encourage them to enter the field of special education.

Broadening Scope of Special Education Programs. Still another issue in special education is the scope of present programs, Parents whose children are enrolled in special education classes and educators and administrators involved in special education have advocated that the scope and breadth of special education programs be expanded. Specifically, they have suggested that children who are educationally handicapped or classified as educable mentally retarded should qualify for special education at age three rather than age five. All the other handicapped programs are available to three-year-olds. Secondly, it has been suggested that the types of special education personnel which are approved for reimbursement include school psychologists, school social workers, mobility specialists (those who teach blind children to function), audiologists, occupational therapists, and physical therapists.

COLORADO CIVIL COMMITMENT LAW

Procedures Under Present Colorado Law

Under current Colorado mental health statutes there are four ways a person may be confined: 1) voluntary hospitalization, 2) emergency custody, 3) short term involuntary hospitalization, and 4) involuntary commitment.

Voluntary Hospitalization

Under the provisions of current law any person 18 years of age or older who is mentally ill or mentally deficient may request to be admitted by any hospital for observation, diagnosis, care, and treatment. A person under 18 years of age may be admitted upon application of his parent or legal guardian. The law provides that a patient is to be discharged upon his request or that of his legal guardian. If the administrative officer of the hospital or the attending physician is of the opinion that release of the patient would be unsafe or dangerous, he may, within five days from filing of the release request, file a written opinion to that effect with the court. The court then proceeds under the short term involuntary hospitalization provisions or the involuntary commitment provisions of the statute.

Emergency Procedure

A sheriff or police officer who in good faith believes a person to be mentally ill or deficient and apt to injure himself or others if allowed to remain at liberty may place that person in custody pending an order of the court. The officer must immediately file with the court a statement setting forth the circumstances of the detention and the reasons for his conclusions as to the mental condition of the person whom he has placed in custody. Within 24 hours (excluding Saturdays, Sundays, and legal holidays) from the filing of the report by the officer, the court must enter an order: discharging the person in custody; confining him for observation, diagnosis and treatment under the short term involuntary hospitalization provisions; or referring the matter to a medical commission appointed under the involuntary commitment provisions of the statute.

Short Term Involuntary Hospitalization

The short term hospitalization statute allows the court to order an individual to be confined for observation, diagnosis, and treatment of mental illness for three months. This period

can be extended by the court for an additional three months whenever it appears from the written statements of the attending physician or the director of the hospital that the original three-month period is insufficient to accomplish the purposes of the hospitalization. Any reputable person can initiate a short term hospitalization proceeding against another individual. He can do so by filing a verified petition to the court of jurisdiction alleging that it would be in the respondent's best interest to be hospitalized. The petition must be accompanied by a statement from a licensed physician also alleging that such observation, diagnosis and treatment would be in the best interest of the respondent.

Proceedings may also be initiated by filing with the court a statement by a physician or administrative officer of a hospital as provided for in the voluntary hospital provision. In addition a medical commission appointed to consider the merits of a petition for involuntary commitment can recommend short term hospitalization as an alternative to long term commitment and adjudication. Finally, a court on its own motion can order short term hospitalization pursuant to emergency detention procedure provisions.

Guardian Ad Litem. Whenever a petition is filed requesting an order for short term hospitalization, the court is required to appoint an attorney to serve as guardian ad litem for the respondent. The duties of the guardian ad litem are outlined by statute. He is specifically charged with three duties: (1) to make such investigation as may be necessary to protect the interests of the respondent; (2) to make certain that the respondent is advised of his right to a hearing either by a medical commission or by a court; and (3) to report the results of his investigation to the court as soon as possible, but no later than five days after the entry of the hospitalization order, unless the court extends the time.

Involuntary Commitment

The petition which is filed for involuntary commitment is similar to that filed for short term involuntary hospitalization. The petition must contain a request for a hearing before a medical commission and must be accompanied by a physician's statement. Upon receipt of the petition or, on its own motion, the court may issue an order directing a designated person to take the respondent into custody, pending determination of his mental condition by a medical commission. A guardian ad litem must be appointed as in the short term involuntary hospitalization proceedings. His duties are in many respects the same as in the short term involuntary hospitalization procedure.

Medical Commission. Whenever an involuntary commitment petition is filed, the court is required to appoint a medical commission to determine whether the respondent is mentally ill or deficient. A commission must be comprised of two medical doctors licensed to practice medicine in Colorado. Upon appointment of the commission the judge orders a time and place for a hearing by the commission. Within 48 hours of the conclusion of the hearing, the commission must file a verified report of its findings with the court. The commission's report must answer the specific questions in the statute as to the nature of the respondent's affliction. If any of the questions are answered in the affirmative, the report is to provide personal information about the respondent and recommend a suitable place for his commitment or a suitable person to be entrusted with custody of the respondent. Additionally, the report must include any conditions of custody which the commission recommends.

If the medical commission finds that the respondent is mentally ill or deficient and recommends indefinite commitment and adjudication, the court must then enter an order within six days after the filing of the commission report. This order adjudicates the respondent mentally ill or mentally deficient and provides for his commitment or custody. If the commission recommends short term hospitalization without adjudication, the court proceeds under the provisions of the short term involuntary hospitalization statute. The statute appears to require the court to follow the findings and recommendations of the medical commission.

Problems and Weaknesses in the Colorado Law

Numerous individuals and groups have criticized Colorado's civil commitment law. The following is an attempt to outline some of the problems which critics of the civil commitment law have cited. Many of the ideas were developed from an article written by Carl E. Johnson, J.D., University of Denver College of Law, 1969, which appeared in the Fall 1969 volume of the Denver Law Journal. The article is entitled "Due Process in Involuntary Civil Commitment and Incompetency Adjudication Proceedings: Where Does Colorado Stand?" Other ideas were developed from discussions with attorneys who have dealt with the commitment law and professionals in the area of mental health.

Period of Treatment and Evaluation

Under present law a person alleged to be mentally ill against whom a petition is filed in court stands the chance of being hospitalized for a period up to six months or committed to

a state institution for an indefinite period of time. Many supporters of the commitment law and procedure believe it has adequate safeguards to insure that a person is not "railroaded" into hospitalization or commitment. However, others feel that more steps need to be taken to prevent persons from being unnecessarily and unjustly committed or hospitalized. Their desire to prevent this from happening stems from their concern to protect individual rights as well as their interest in insuring that our hospitals and institutions are not crowded with persons who cannot benefit from the care and services they offer.

One suggested safeguard is that any allegedly mentally ill person against whom a petition has been filed may be ordered by the court to submit to 72-hour evaluation. This period of evaluation would be a prerequisite to any other court action in emergency detention or involuntary hospitalization proceedings. In addition, it is also suggested that prior to the actual filing of a petition in court, the Department of Institutions be required to provide pre-petition screening to determine that there is probable cause to believe the allegations in the petition. The screening would serve two functions: 1) it could be used to determine whether the person would agree voluntarily to counseling or treatment; and 2) it would serve to screen out those petitions where there is not probable cause to believe that the person is in fact mentally ill.

Vague Statutory Standards for Compulsory Hospitalization and Commitment

Proponents of changing the present commitment statutes contend that the commitment statute should contain a reasonable definition of the term "dangerous" and some argue that only those individuals who are dangerous to themselves or to others or are gravely disabled should be hospitalized. They point out that compulsory hospitalization and commitment proceedings have traditionally been justified by the courts because they benefit the individual subject to them. Skeptics of this "benefit" theory question if in practice these benefits are realized by most of the committed or hospitalized individuals. They argue that the commitment statute should be designed to insure that only those persons who actually need hospitalization are confined.

Specifically, advocates of an amended commitment law contend that phrases such as "in the best interest of", "own welfare", etc., are too broad and vague. The court or medical commission should have definite standards on which to base their decisions and report how their decisions are in the best interest of the individual.

Statement of Licensed Physician

Under present law a physician's statement must accompany a petition for hospitalization. The physician submitting the letter is not required to be a specialist in mental disorders. Presumably his letter could be based on only a cursory examination or interview. As a result people may be forced into care in mental hospitals who are not suited for the kind of care offered by these institutions.

To remedy this situation, it has been suggested that the requirement of a physician's letter be abolished and instead each petition for short-term hospitalization be referred to a team of mental health professionals whose job it would be to investigate the matter and make recommendations to the court as to the best course of action. However, it is suggested that the court should not be bound by the recommendations of the team but the recommendations should weigh heavily on the decision of the court. It is also recommended that such a mental health team should make a serious attempt to get the individual to voluntarily accept their recommendations before resorting to any compulsory process.

The Medical Commission

Medical commissions are comprised of doctors in private practice who are appointed to serve and are usually compensated on a per case basis. It is noted that doctors are often reluctant to serve because it means time away from their own generally more lucrative private practices. It is argued that the proper place for a hearing to determine if compulsory hospitalization should be imposed is before a court, not a medical commission. Courts have the experience to maintain an orderly procedure, conduct a fair hearing, and weigh evidence properly.

Two specific recommendations have been discussed concerning medical commissions. One is that they be abolished and that hearings be conducted by a judge whose special skill and function is to hear commitment cases. A second recommendation applies if the medical commission is to be retained. Duties of the commission should be more specifically defined and a procedural format for conduct of commission hearings spelled out statutorily or in court rules. It should also be noted that there are others who recommend jury trials in mental health proceedings.

Counsel for the Respondent

Many attorneys argue that the greatest single need from a due process standpoint in the commitment proceedings is the need for every respondent to be furnished with effective counsel.

They contend that the guardian ad litem does not adequately fulfill this function. One reason is attributed to the vagueness of the statutes in outlining the duties of the guardian ad litem. For example, the statutes require that the guardian ad litem make such investigation as may be necessary to protect the interests of the respondent. However, the law does not spell out what the interests of a respondent are or what kind of investigation is adequate in such cases. The recommendation is made that the role of the counsel be spelled out in greater detail in the statutes.

Under present practice guardians ad litem are usually selected from the rosters of the county bar associations. However, the attorneys appointed are generally those who have informed the court clerks of their desire to receive court appointments. These are frequently lawyers recently admitted to practice. The compensation for services as guardian ad litem is low, and many attorneys feel that the fee does not justify going beyond the bare statutory requirements. Because there is little incentive to go beyond the minimum duties, few attorneys do more than is essential. For these reasons it has been suggested that whenever possible a full-time public defender staff should be established to deal with mental health matters.

Proponents of this latter idea contend that the low rate of compensation is a major reason for the ineffectiveness of counsel in mental health cases, yet they realize that to pay an attorney a fee comparable to what they receive in private practice would strain the public financial resources. A full-time salaried professional staff could avoid this problem. They suggest that counties with low rates of hospitalization and commitment activity could be joined together to form public defender districts. In addition, they point out that public defense attorneys could easily be given special training in the mental health field. They add that their daily involvement in the mental health field would undoubtedly make them more effective in the area than attorneys who work only infrequently in the field.

Examination by an Independent Psychiatrist

A further safeguard of the respondent's rights suggested by proponents of a modernized commitment law would be to grant the respondent the right to an examination by a psychiatrist not associated with any state agencies or institutions. They suggest that the testimony or report of this expert should be accorded as much weight as those of the treating team. This recommendation would apply primarily to a person already involuntarily hospitalized and seeking periodic review of his case. It is suggested that the psychiatrist should be obtained at the patient's expense unless he is indigent and then the Department of Institutions would be responsible for obtaining and compensating a physician if requested in writing by the patient.

Adjudication Proceedings

Today an adjudication serves as blanket judgment of incompetency for all legal purposes. Opponents of this procedure point out that a person may be mentally incompetent for one purpose but not for another. For example, an individual may be mentally incompetent to make a will but not possess that kind and degree of incompetency which would justify compulsory confinement. A suggested remedy to this process is that the judicial, adjudication, and hospital proceedings should require the court to make specific findings concerning each right or portion of liberty which the respondent is alleged to be mentally incompetent to enjoy.

Periodic Review of Commitment Cases

Presently, when an individual is adjudicated and committed he is placed in the hands of institutional administrators and cut adrift from the legal process, which for all practical purposes, takes no further interest in him. The law does provide that the respondent has the right to communicate with an attorney and with the judge of the court. However, the law does not provide a meaningful mechanism through which such communication can take place. Because it is possible that a patient could become a forgotten person as far as the legal system is concerned a number of safeguards outlined in the following paragraph have been suggested.

The legal system should be obliged to demonstrate a continuing interest in those compulsorily placed in the custody of mental health agencies. All such orders should be reviewable periodically, perhaps every three or four months, by the court. The public defender, or guardian ad litem if retained, should be required to contact every respondent at the end of this same period to discuss his treatment with him, and also make an independent investigation (e.g., by interviewing the treating doctors, etc.) of his treatment and prognosis. The defender would be required to submit a report of his investigation to the court. At every such interval the respondent, by himself or through the public defender, should be able to demand a court hearing, challenging either the confinement or custody as such or challenging the manner of treatment or confinement. This however should not preclude the availability of court review between these particular dates if extraordinary circumstances warrant it.

If the law were amended to allow for periodic review, it would also have to make clear where the burden of proof would lie. Would it be the responsibility of the institution to prove that the patient should be confined, or must the patient prove he is well?

Voluntary Hospitalization "Hold" Provision

The present voluntary hospitalization statute allows any hospital to detain a voluntarily admitted patient up to five days (excluding Saturdays, Sundays, and holidays) after he has filed a written request for release, if hospital officials believe that he is mentally ill or that he displays symptoms of mental illness or deficiency. This power to detain is greater than that exercised by peace officers under the emergency detention statute. Under the emergency detention statute, the peace officer must have cause to believe the individual is dangerous to himself or others in addition to a belief that the individual is mentally ill or deficient.

Opponents of this five-day "hold" provision say that it may discourage voluntary hospitalization and call for its repeal. They point out that the emergency detention provision is sufficient to handle a person who is a threat to himself or others. Otherwise, they contend that if the hospital officials believe that a patient needs further compulsory treatment, they should be required to follow the provisions of the short term hospitalization statute without the benefit of a lengthy "hold" period exercised at their own discretion without judicial supervision.