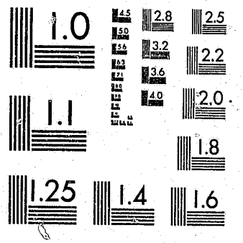

MENTAL ILLNESS AND VIOLENCE

16

AN ISSUE IN CRIMINAL JUSTICE AND MENTAL HEALTH

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DEPARTMENT OF
LOCAL AFFAIRS

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MENTAL ILLNESS AND VIOLENCE:

AN ISSUE IN CRIMINAL JUSTICE AND MENTAL HEALTH

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January 1982

ACKNOWLEDGMENTS

The Mental Illness and Violence study could not have been completed without the assistance of many people and agencies. We are very grateful to the researchers, social workers, doctors, and administrators at the Division of Mental Health, Fort Logan, Colorado State Hospital, and Boulder Mental Health Center for lengthy interviews, orientation tours, and sharing data and reports. We also appreciate very much the contributions of time and thought which went into interveiws with personnel from the mental health centers, the courts, district attorneys and public defenders, police and sheriffs' departments, and emergency facilities. Other special debts of gratitude are owed to the entire staff of the Division of Criminal Justice for their support work and technical assistance, and all those others who so patiently and courteously answered our many questions and volunteered valuable advice.

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INTRODUCTION

This report, Mental Illness and Violence: An Issue in Criminal Justice and Mental Health, is presented in response to a request from the Department of Institutions for the Division of Criminal Justice to prepare an analysis and convene a task force to address issues related to information exchange, standardized procedures, cooperation between criminal justice and mental health agencies, and preventive detention of dangerous mentally ill persons.

To this end, the Division surveyed a sample of agencies involved in identifying, detaining, admitting or committing, treating, releasing, and following up the mentally ill dangerous or potentially dangerous person, and established a task force to consider the issues and make policy recommendations to the Department of Institutions.

For the study, the dangerous mentally ill person (DMIP) was defined as follows:

> Any individual who is suspected of being or has been diagnosed as mentally ill, and who has either been arrested for allegedly committing or attempting to commit a crime against a person or has been hospitalized for allegedly committing such an act even though the act was not formally defined as a criminal offense by a law enforcement agency. Crimes against persons include homicide, sexual assault, assault, robbery, kidnapping, and arson.

In addition to a literature review and official state reports, three types of data were sought from the criminal justice and mental health agencies in the sample:

> Information provided by agencies such as reports and copies of procedures and organizational structure.
>
> Agency level information on the number and type of clients (DMIP) processed by each agency. Only four agencies were able to provide a part of this information.
>
> Interviews with agency representatives were conducted in order to describe relationships between agencies, problems, procedures and practices, and recommendations.

TASK FORCE

A task force of criminal justice and mental health practitioners was established to review the findings of the survey and to make recommendations to improve the systems' response to the dangerous mentally ill. The task force, chaired by Dr. Dennis Kleinsasser of the Department of Corrections, met the summer and fall of 1981.

The discussion of the task force centered around the identification and definition of the problems encountered in providing care and treatment to the dangerous mentally ill, while protecting the public. The findings of the survey of criminal justice and mental health practitioners, conducted by the Division of Criminal Justice in the spring of 1981, were presented to the task force. Also presented for consideration were the major findings of several recently completed studies in Colorado which address a part or all of the issues being discussed by the task force. Descriptions of cases involving dangerous mentally ill clients as well as members personal experiences were presented to illustrate several of the statutes, procedures and practices which impede the effective coordination between agencies when handling a dangerous client.

The task force made numerous recommendations which are included in the report after a discussion of the problem being addressed. The recommendations include statutory changes, changes in procedures and practices, and requests for additional resources and recommendations for the better utilization of existing resources. Some of the recommendations will require additional appropriations by the Legislature. However, many of the recommendations could be implemented with little or no additional cost to the system. The recommendations will be presented to the Governor through the Division of Mental Health and will be presented to the various professional organizations by the members of the task force.

Copies of the minutes of the meetings are included in Appendix B of the report. The task force was composed of the following members.

Judge Donald Abram
Federal Court Magistrate

Patrick Ahlstrom
Chief, Broomfield Police

Stephen Block
Director, National Association of Social Workers

Tarquin Bromley
Assistant Attorney General

Richard Castro
State Representative

Dr. Herman Diesenhaus
Division of Alcohol/Drug Abuse

Thomas Gilmore
Sheriff, Montrose County

Dr. Robert Glover
Division of Mental Health

Dr. Laurence Greenwood
Larimer County Mental Health Center

James Joy
Director, ACLU

Dr. L. Dennis Kleinsasser, Chair
Department of Corrections

Dr. Dennis Pearson for Dr. Haydee Kort,
Director, Colorado State Hospital

Doris Kyle
Director, Centennial Mental Health Center

Gregory F. Long
District Attorney

Betty I. Neale
State Representative

Murray Richtel
District Judge

Yuolon Savage
Director, Adams County Mental Health Center

John Simonet
Director of Corrections

Donald P. Smith, Jr.
Judge, Court of Appeals

Dr. S.Z. Sundell
Forensic Psychiatric Ward 18

John Tagert
Chief, Colorado Springs Police

Nancy Terrill
Assistant Boulder County Attorney

Guy Till
Deputy District Attorney

Dr. Frank Traylor
Director, Department of Health

Bob Husson and/or Rita Berrares for
Ruben Valdez, Director
Department of Social Services

Several other people, although not officially members of the task force showed an interest in the issues and participated in the discussion and formulation of the recommendations:

Irene Cohen
Division of Alcohol/Drug Abuse

Harriet Hill
Adams County Mental Health Center

Ambrose Rodriguez
Division of Mental Health

Sarah Sammons
Assistant Attorney General

Linda Schuman
Denver District Attorneys' Office

Tiana Yeager
Division of Mental Health

SUMMARY AND RECOMMENDATIONS

Public alarm about violent acts by former mental health patients has led to much criticism of the mental health and criminal justice systems' handling of the mentally ill violent or potentially violent person. In response to this criticism, and in an effort to better serve this population, the Department of Institutions requested that the Division of Criminal Justice prepare an analysis and convene a task force to address the following issues:

a more integrated data system

more unified procedures and policies

methods for establishing more mutual understanding of the three systems and a permanent mechanism for addressing common problems

public policy of preventive detention and the issues which result from it

- what set of conditions are necessary for a dangerous person to be civilly committed and held, and for how long?
- what kind of and amount of security is necessary and legal to control the dangerous civilly committed patient?
- at what point in a criminal commitment or a civil commitment for dangerousness to others should a patient be released?
- what should be done with a dangerous and mentally ill person who appears to be untreatable?

This report represents the response to this request. In order to prepare the analysis, the Division of Criminal Justice collected information from several sources. A statewide survey consisting of intensive interviews with criminal justice and mental health practitioners focused on problem identification and recommendations, and included a description of how the existing system functions. Other research conducted included:

a review of policies and procedures currently in use at each agency

an analysis of Division of Mental Health admissions data

interviews with selected agencies to develop a profile of DMIP case processing

a review of the literature on dangerousness and mental illness

a review of state reports and publications on the mental health system and on dangerousness research

The Task Force on the Dangerous Mentally Ill was convened on June 26, 1981. As requested by the Department of Institutions, the task force was composed of representatives from the state's executive, legislative and judicial branches and from both the mental health and criminal justice systems which have operating or policy making responsibility for dangerous mentally ill persons.

The first meeting was devoted to presentation and discussion of the research findings. At the second meeting, issues were defined and the small group approach to problem solution was adopted. The primary issues to be addressed were defined by the task force as:

who is responsible for the dangerous mentally ill?

does a new system for the care and treatment of the dangerous mentally ill person need to be developed or should changes to the current system be made to certain areas?

The task force reached a general consensus that although the mental health system works well for the general population, some kind of specialized program is needed to deal with dangerous mentally ill patients, and that statutory changes are needed which will allow information exchange between agencies and give the courts more control than they now have. The items discussed by the subgroups were:

what should a new system or program consist of?

who should have oversight authority for the system or program?

what statutory changes are needed to implement the new system or program?

The groups' combined efforts resulted in a preliminary model for identifying and delivering services to dangerous mentally ill clients (see page xi).

At the third meeting, the focus of the task force narrowed. Dr. Robert Glover, Director of the Division of Mental Health, asked task force members to keep their tasks small enough so that they could be accomplished within a reasonable time frame. Dr. Glover stated that the original charge of the task force was for one or two meetings in which concrete recommendations could be developed and implemented by individual task force members in the agencies they represent. Task force members were then asked to develop specific prioritized recommendations for improvement of the system.

Task force members, however, felt it was important that they make some very concerete recommendations about how to proceed in the present system while at the same time looking at more long term solutions. They perceived the issues as too serious to be addressed only on a short term basis, and felt the larger issues should be discussed to set goals and priorities for the future. Thus, the task force decided to hold additional meetings in order to try to address both broad and narrow issues. Because of the narrowing of the focus and the funding constraints which exist in the state, the task force made recommendations which they feel are the best that can be done under the circumstances. Therefore, the recommendations, if implemented, would result in an improved delivery of services but would fall short of an ideal system.

Task force members were very concerned about the cost of recommendations. While not optimistic about funding for new programs in the current economic and political environment, they nevertheless felt they should state the need for such funding to make it clear that needs could not be adequately met by transferring funds from one agency or program to another. They did not, for example, want to recommend more funding for dangerous mentally ill at the expense of delivery of mental health services to other segments

of the population who, although not dangerous, are in need of mental health services.

Task force members also confronted the difficult task of attempting to reconcile public safety considerations with individual rights of patients.

Central to this issue of preventive detention is the identification of individuals who are dangerous as a result of mental illness, and legal criteria for involuntary detention. Task force members were generally divided on this issue along mental health - law enforcement lines.

The complexity of the issues addressed by the task force is reflected in their discussions reported in the minutes (Appendix B). They requested, however, that a statement be included in the report to express the pain and frustration caused by their attempt to solve such serious problems within the existing funding, legal, and political constraints.

CONCLUSIONS AND RECOMMENDATIONS

The survey of criminal justice and mental health practitioners, review of the national and state literature, and the task force meetings were organized around the four major issues outlined in the introduction to this report. Some issues, however, have been given more attention than others. The security issue, for example, has not been a primary concern of this project since the Division of Mental Health conducted a study and implemented recommended changes.

The task force recommendations on the remaining issues provide the incentive for developing and implementing an integrated data system, uniform policies and procedures, and mutual understanding between the criminal justice and mental health systems. In addition, there are recommendations for developing a public policy on preventive detention and other related issues. The task force divided the recommendations into low cost and high cost recommendations and then ranked and prioritized each group. It should be noted that low cost recommendations refer to changes to the sytem which could be implemented with little or no money. Only recommendations which were ranked at or above the median score are reported here. The complete list of task force recommendations with their scores and rankings are provided in Appendix B , p. 151. All recommendations shown in this section of the report are listed under each issue in the general order of their importance as prioritized by task force members. A brief summary of applicable task force discussion is included preceding each group of recommendations. The minutes of task force meetings contain the details of their discussions.

ISSUE

The public policy of preventive detention and the issues which result from it.

What set of conditions are necessary for a dangerous person to be civilly committed and held and for how long?

What kind of and amount of security is necessary and legal to control the dangerous civilly committed patient?

At what point in a criminal commitment to the mental health system or a civil commitment for dangerousness to others should a patient be released?

What should be done with a dangerous and mentally ill person who appears to be untreatable?

Discussion

Task force discussions pertaining to the policy of preventive detention focused primarily on the "untreatable" patient, system responsibility, and lack of resources. The task force felt that the issue of detention as treatment for resistive violent patients should be confronted, and a special program developed for them. Other facets of preventive detention discussed were criteria for commitment, liability, the right to treatment, and confidentiality.

This was the area in which tensions among task force members were most evident. The task force struggled with the question in terms of:

1. Creating a new structure or modifying the existing system.
2. Need for new money or no new money.
3. Transfer of money from one client population to another.
4. Patients' rights vs. public safety.

The issue of preventive detention is very broad and several of the low cost recommendations presented under the following issues are also related to it. For example, the recommendations for statute changes, education on what can and cannot be done under the statutes, better communication between the systems, more integration of data on dangerous mentally ill persons, and the creation of a centralized program.

Task force members strongly felt, however, that effective policies for preventive detention require a resource base for providing services to the whole spectrum of mentally ill clients. They therefore recommend increased funding for expanding services provided in the existing system, as well as for new programs specifically designed for dangerous mentally ill clients.

Task Force Recommendations

THERE IS A CRITICAL NEED FOR A SUBSTANTIAL INCREASE IN BOTH THE NUMBER OF SECURE AND NON FORENSIC PSYCHIATRIC BEDS IN ORDER TO PROVIDE THE CAPABILITY OF TREATING THE DANGEROUS MENTALLY ILL.

- THERE SHOULD BE MORE BEDS AND A BETTER STAFF/PATIENT RATIO AT COLORADO STATE HOSPITAL, FT. LOGAN, AND THE DENVER AREA.

- THERE SHOULD BE MORE INTERMEDIATE SECURITY BEDS AT COLORADO STATE HOSPITAL.

- THERE SHOULD BE A GREATER NUMBER OF SECURE BEDS IN DECENTRALIZED LOCATIONS.

A FORENSIC OBSERVATION UNIT SHOULD BE ESTABLISHED IN THE METRO AREA.

FOLLOWUP AND CONTINUATION OF CARE SERVICES SHOULD BE EXPANDED.

- DANGEROUS MENTALLY ILL PERSONS SHOULD BE PROVIDED FOLLOWUP AND CONTINUATION OF CARE SERVICES ON A NON-CATCHMENT AREA BASIS.

- THERE SHOULD BE DECENTRALIZED SHELTERED WORKSHOPS.

- THERE SHOULD BE INCREASED FUNDING TO LOCAL MENTAL HEALTH CENTERS FOR CONTINUATION OF CARE FOR NON-DANGEROUS CRIMINAL JUSTICE CLIENTS.

ISSUE

The need for a more integrated data system.

Discussion

Task force members agreed that the lack of information exchange in the current system results in many problems affecting decisions made by both the criminal justice and mental health systems regarding the dangerous mentally ill. Specific cases were cited where individuals were released or escaped and committed a violent crime because the necessary information was not available to make the proper decisions. Also discussed was the issue of liability regarding information exchange and the need for possible changes in legislation. Mental health practitioners are afraid of lawsuits which may result from divulging information on clients, but several judicial representatives see the risk as negligible where "good faith" actions are concerned. Several members were very concerned about changing safeguards in such a way that information on mental health clients who are not dangerous would be more accessible. There is a consensus on the mental health system's need for offense related information; however, the recommendation for sharing information on mental health activities was given a low priority.

Task Force Recommendations

COMMUNICATION BETWEEN AND WITHIN THE MENTAL HEALTH SYSTEM AND THE CRIMINAL JUSTICE SYSTEM SHOULD BE IMPROVED.

- A FULL POLICE REPORT REGARDING THE INCIDENT AND CRIMINAL HISTORY SHOULD BE TRANSFERRED WITH PERSONS REFERRED TO MENTAL HEALTH CENTERS BY THE POLICE.

- THERE SHOULD BE A BETTER TRANSFER OF INFORMATION BETWEEN THE COURTS AND MENTAL HEALTH FACILITIES. THE SOURCE OF ALL INFORMATION SHOULD BE IDENTIFIED BEFORE IT IS TRANSFERRED TO ANOTHER AGENCY.

- BETTER USE SHOULD BE MADE OF THE PRESENT STATUTES REGARDING EXCHANGE OF INFORMATION BETWEEN TREATMENT AGENCIES.

- LOCAL JURISDICTIONS SHOULD SET UP A MECHANISM FOR EXCHANGING INFORMATION TO INCLUDE COMMON WRITTEN GUIDELINES. MENTAL HEALTH CENTERS SHOULD TAKE THE LEAD. EXTERNAL HELP IN SETTING UP THESE MEETINGS SHOULD BE PROVIDED BY TASK FORCE MEMBERS, THE DIVISION OF MENTAL HEALTH OR THE DIVISION OF CRIMINAL JUSTICE STAFF, OR OTHERS TO PROVIDE PERTINENT MATERIALS REGARDING PROBLEMS OR ISSUES TO BE ADDRESSED.

ISSUE

The need for uniform practices and procedures.

Discussion

The task force identified the lack of standard procedures as a major impediment to effective placement and treatment of dangerous mentally ill persons. A good example of this is the "dumping" syndrome, where patients are shunted from one agency to another as each attempts to pass on responsibility for the client. The end result is duplicated services (evaluations) and costs, and failure to provide adequate care to the patient. Basically, the task force saw a problem in organization for delivery of services to dangerous mentally ill persons and in the legal system. They felt that although mental health centers do a good job for the majority of clients with mental health problems, the centers were not set up to deal with dangerous clients.

With no central coordinating program for these clients, the multitude of agencies involved in the care of dangerous patients develop practices independent of other agencies. The task force also felt that different practices and procedures result from the ambiguity of many of the terms used in the mental health statutes as well as a lack of clarity about who has authority, and also, that technical problems are caused by some of the time requirements specified in the statutes.

The complete list of recommendations reflect the tension task force members felt between recommending changes to the current system and recommending a new system. There are recommendations for both (see Appendix B, p.151). They felt that if the current system is asked to handle dangerous mentally ill persons, changes must be made to insure proper care and treatment while providing for public safety. They see many problems arising from the interface between the two systems, which require development and application of standard procedures for law enforcement, mental health, and the courts.

Task Force Recommendations

THERE SHOULD BE IMPROVED STANDARDS FOR THE TREATMENT OF DANGEROUS MENTALLY ILL PATIENTS COMBINED WITH ACCREDITATION PROCEDURES FOR THE MENTAL HEALTH CENTERS. SITE VISITS SHOULD BE MADE BY SUPERVISING OFFICIALS TO INSURE COMPLIANCE WITH THESE STANDARDS.

A MULTI-DISCIPLINARY COMMITTEE SHOULD BE ESTABLISHED TO REVISE AND DEVELOP MODEL STATUTES.

- ONE SPECIFIC AREA FOR THE COMMITTEE TO ADDRESS IS THE NEED TO ENFORCE MEDICATION FOR THOSE INDIVIDUALS WHO ARE VIOLENT TOWARDS OTHERS. A NECESSARY CHANGE IN THE STATUTE WOULD INTRODUCE A PROCEDURE WITH CRITERIA SIMILAR TO THOSE IN INCOMPETENCY PROCEEDINGS.

THE SERVICE AREAS FOR THE TWO HOSPITALS SHOULD BE ELIMINATED OR REDEFINED.

ISSUE

Methods for establishing more mutual understanding of the criminal justice and mental health systems and a permanent mechanism for addressing common problems.

Discussion

The need for better communication between criminal justice and mental health was discussed throughout the task force meetings. Mental health workers and police officers, for example, fail to show mutual respect and understanding of agency purposes, mandates, and limitations. Some members reported that steps had already been taken to improve realtionships. The Division of Mental Health has appointed a criminal justice liaison and the Division of Alcohol and Drug Abuse has assigned a person responsibility in this area. Several police departments also have a mental health liaison.

Task Force Recommendations

MORE EDUCATION/TRAINING SHOULD BE PROVIDED TO MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES AND THE LEGAL SYSTEM REGARDING WHAT CAN AND CANNOT BE DONE UNDER THE CURRENT STATUTES. THERE SHOULD BE CROSS TRAINING BETWEEN MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES.

MODEL FOR DELIVERY OF MENTAL HEALTH SERVICES TO DANGEROUS MENTALLY ILL PERSONS

As previously discussed, task force members feel that the existing system is inadequate for meeting the needs of dangerous mentally ill patients and for protecting the public. Therefore, the task force developed a model for a new program which would provide services for this client population. The model has not been fully developed, but should serve as a blueprint for planning and implementation of this program. It should be noted that the current system operates well for most clients and that this new program would serve only those dangerous clients who cannot be adequately served by the current system.

DEFINITION

The task force defined the dangerous mentally ill patient as a person with a mental disease or defect who because of it either is dangerous to others or has a demonstrated capacity to commit violence.

CONCERN FACTORS

The following factors should not be used as predictors of dangerousness, but as variables of concern which should alert criminal justice and mental health practitioners that further evaluation may be appropriate.

- History of Violent Acts:
  - How Frequent
  - How Serious
  - How Recent
- Drug or Alcohol Abuse
- Clinician's Judgment
- Stress in Precipitating Situation
- Employment Instability
- Housing Instability
- Socio-Economic Status
- Violent Ideas
- Paranoid Ideas
- Hallucinations
- Verbal Threats
- Bizarre Behavior
- Intense Motor Activity

There are no reliable data which indicate how many dangerous mentally ill patients Colorado has. However, there are several indicators which provide a high and low estimate of the number of dangerous mentally ill persons in the community.

Sutherland Miller, former director of the Division of Mental Health, asked mental health centers and clinics to identify all current or past clients who had committed a violent crime within a 10 month period starting July 1, 1979. The information he received was used to derive an estimate of 613 dangerous mentally ill clients in the state who actually committed a violent act during this 10 month period.

An analysis of Division of Mental Health intake data produces another indicator. In FY 1979-80, 3,233 of the 50,542 admissions were clinically assessed as being a danger to others and 1,825 of these had also committed offenses against persons. These figures both underestimate and overestimate the popu-

lation in different ways. The population is underestimated in that institutions do not evaluate all dangerous mentally ill persons in the community. It is an overestimate in that multiple admissions are characteristic of this population. If a correction factor of 10 percent is included to account for multiple admissions, the estimate is 2,900.

There is another significant population which is not included in these figures - those which are held in institutions and jails. Dangerous mentally ill persons are sometimes held in local jails becasue mental health services are not available. An estimated 50-60 dangerous mentally ill persons are held at different times in the Denver County Jail alone.

Thus the estimated numbers of dangerous mentally ill persons in the community are:

631* low estimate
2,900* high estimate

These are only rough indicators of the number of dangerous mentally ill persons who could be better served by the new program which is being proposed. This is not to say that all these people would be referred or that all of these would be in the program at one time. It should also be noted that if a continuum of services is provided, residential treatment would not be required for all persons referred to the program.

The system to treat the dangerous mentally ill should have the following characteristics. It should be:

- state managed and operated to insure continuity of care from hospitals to community placement.
- In addition to their own caseload, the mental health centers should provide the evaluative services for those persons suspected of being dangerous as a result of mental illness which are referred by jails, courts, drug and alcohol facilities, or other mental health entry points. The state system should reimburse the mental health centers for such evaluations which are not a part of their existing caseloads.
- A person identified by a mental health center as dangerous as a result of mental disease or defect, would be referred to the state system.
- Inpatient services should be centralized in one or more locations in the state. In addition, the system will provide all levels of partial care and outpatient treatment.
- Resources should be provided to purchase or create needed services. Independent sheltered workshop or boarding houses may be needed separate from currently existing community mental health centers and community corrections facilities.

*These figures do not include those held in jails or institutions.

- The authority to purchase or create needed services (e.g., group and individual therapy, counseling, A.A., halfway houses or sheltered workshops.
- A case manager system should be established throughout the state. A case manager would arrange and monitor the necessary long term services to include group and individual counseling, A.A., halfway house or sheltered workshops. The case manager would supervise a case regardless of the type of service being delivered.
- The case manager would be employed by the state.
- A long term treatment plan for each client would be developed.
- The case manager would have the following characteristics:
  1. clinical training in working with dangerous mentally ill persons
  2. the authority of a peace officer as defined in C.R.S. 27-10 and 25-1-311
  3. authority to institutionalize in accordance with the law
  4. access to all client records
  5. authority to arrange for the administration of involuntary medication in accordance with the law
  6. access to placement alternatives
- Continuity of care procedures should be followed when exiting from the system.

IMPLEMENTATION

Although the task force has officially ended its work the majority of the task force members are interested in working further to implement several recommendations. Nine members expressed an interest in working in a group to develop model statutes for the care of dangerous mentally ill patients, and seven, on developing procedures for information exchange between criminal justice and mental health agencies.

Several additional members expressed an interest in working with the Division of Criminal Justice in providing cross training for those providing services to mentally ill persons held in local jails. Plans are being considered to do some further work on implementation of task force recommendations.

CHAPTER I: THE DANGEROUS MENTALLY ILL PERSON: A NEW BODY OF LAW AND LITERATURE

Dangerous mentally ill persons have long been a problem for mental health and criminal justice systems, but never more than today, when these systems must contend with the opposing forces of public demand for protection and the increasingly stringent and narrow commitment and treatment procedures.

As a result, a large body of literature has been produced on this subject. This literature is broad and diverse, ranging from very technical papers on organic or physiological causes of violent behavior to qualitative accounts of how police officers and social workers make the decisions which lead to the labeling of a person as mentally ill and dangerous. In the interest of parsimony, however, this review will focus on a view of the issues of major concern to Colorado. First, changes in mental health law will be reviewed; second, the concept of dangerousness as a criterion for acting will be discussed; and, third, several precedent setting Colorado mental health cases will be summarized.

CHANGES IN MENTAL HEALTH LAW

Over the last decade there has been a national movement to deinstitutionalize the mentally ill. When it began, any person certified as mentally ill and in need of treatment could be involuntarily confined. The social changes of the 60's and 70's included great changes in mental health law, beginning with involuntary detention and commitment.

Three major arguments supported the deinstitutionalization movement:

1. The well-documented adverse effects of incarceration.

2. Satisfactory alternatives to institutionalization.

3. The moral view that persons should not be deprived of any more liberty than necessary to achieve legitimate government goals (Wexler, 1976:4).

The efforts of mental health and prison reform lawyers and changing attitudes by the courts have brought about a new system of mental health law. The early cases cited the vagueness of commitment criteria. These criteria made all mentally ill persons subject to involuntary detention for indefinite periods of time. The issue was eventually resolved in the supreme court in O'Connor vs. Donaldson, 1975 . The Donaldson case established dangerousness as the criterion for commitment. The court ruled that a mentally ill person may not be involuntarily committed if he is not dangerous to anyone and if he can "live safely in freedom." Thus, the court left room for the inclusion of "gravely disabled" within the category of dangerousness.

The "dangerous as a result of mental illness" criterion for commitment has placed a greater responsibility on the mental health system and the courts

for involuntarily hospitalizing only those patients whose continued freedom would pose a threat to themselves or others. As stated by Robitscher, two legitimate interests must be reconciled, the preservation of individual liberties and the protection of the public:

> While the individual has an interest in being cared for, he also has an interest in not being cared for. There is an interest in determining one's own care, if the mental ability exists to decide what is in his best interest. Involuntary commitment is reserved for those whom society, or the psychiatric profession, feels are unaware that hospitalization will benefit them; who protest, or have no opinion, concerning a hospitalization that to other "more rational" observers seems necessary.
>
> Society has an interest in preserving individual liberties, but it has another interest in protecting itself from harm. To the extent that society emphasizes liberty and the freedom of choice to make one's own mistakes, we will have stringent commitment policies, fewer patients committed, and more risks in society. To the extent that society believes in the usefulness of a therapeutic involuntary holding, and to the extent that the safety of the individual and of others seems more important than individual autonomy, we will have more liberal commitment standards, more patients committed, and a minimization of risks in society. Physicians and hospitals have an interest in holding patients for therapeutic purposes, but they also have an interest in not being forced to hold more patients than they can treat; therefore, economical and logistical factors enter into the decisionmaking process. (Robitscher, 1979:61-62)

The difficulty in reconciling individual rights with the public safety gives rise to other conflicts. Dangerousness is synonymous with violent behavior, behavior which, in the absence of mental illness, is criminal. Thus, two people may be incarcerated for committing the same act, but one may be punished as a criminal, the other treated as mentally ill.

The mental health rights movement was successful in other areas also: the right to treatment; the right to refuse treatment; informed consent; and the right of privacy (confidentiality). Several of these issues are discussed further in the summary of Colorado case law.

The law continues to evolve on most of these issues. Mental health professionals and the courts find the "dangerousness" criterion as vague and open to subjective interpretation as the old "mentally ill" criterion. The reduction of Parens Patria power and the provision of due process to mentally ill patients have called into question the ability of psychiatrists and mental health professionals to assess dangerousness and to know "what is best for the patient."

The fact that a person's liberty is at stake whether through Parens Patria power or police power has been used in the state courts by lawyers arguing that the standard of proof for involuntary civil commitments should be changed from a "preponderance of the evidence" to "beyond a reasonable doubt"

as it is in criminal proceedings. Criminal law is based on the philosophy that it is better to let ten men go free than for one to be unjustly punished. The question being debated is, should those thought to be mentally ill be afforded less stringent legal protection than those being tried on criminal charges?

The changes in mental health law have also increased liability for decisions made by mental health professionals and police. Psychiatrists find themselves in a double bind. For example, two Florida psychiatrists were ordered to personally pay $38,500 for holding a patient too long without adequate treatment (the Donaldson case), while in another case, the U.S. Government was assessed $100,000 in damages for prematurely releasing a patient who murdered his wife 55 days after his release (Robitscher, 1979).

In addition to continued vagueness, the new mental health laws have also been criticized as being too narrow. The term "dying with their rights on" has been used to describe patients who need treatment but do not meet involuntary commitment or treatment criteria. Dr. Darold A. Treffert, Director of the Mental Health Institute, Winnebago, Wisconsin, talks about the destruction of family life:

> Sometimes the family of a psychotic mother may literally disintegrate while vainly trying to construct some form of routine family life around the mother's bizarre and often psychologically destructive symptoms. In addition, the wife of a mentally ill man may finally abandon her struggle to keep the family going, wearied by fruitless attempts to patch together the semblance of a normal marriage. (Treffert, 1974, quoted in Robitscher, 1979)

Although one of the motives for the deinstitutionalization movement was the provision of alternative and more appropriate treatment, in many cases these alternatives have not materialized or have been inadequate to meet the demand. Thus, the chronically mentally ill are often lost in the shuffle.

DANGEROUSNESS AS A CRITERION FOR COMMITMENT

The criterion of dangerousness led to the development of a whole new area of expertise and a new body of literature on the definition and prediction of dangerousness. The courts asked psychiatrists to step into the vacuum, and assess dangerousness where they had formerly assessed only mental illness. Psychiatry complied, though now many in the profession disclaim any expertise in the assessment of dangerousness, and object to being put into the position of social control agent rather than benefactor and healer.

This perceived role conflict can be the source of many problems between criminal justice and mental health, such as a reluctance by mental health professionals to comply with police requests for assessments of dangerousness, mutual animosity, and lack of cooperation. Not all the experts agree that the role of social control agent and healer are inherently conflictive. Monahan (1981:38) argues that all human service professions have a social protection component, and Halleck (1979), citing the philosophical bias against social control, argues that this dimension of psychiatry should be recognized so that responsible decisions could be made.

Extant research bears out the mental health professionals' claim that they are not expert in the assessment of dangerousness. But the question remains, how accurately can anyone assess dangerousness given existing organizational, political and technical problems. Among the most serious technical problems are the definition of dangerousness, indicators (evidence) of dangerousness, and the low base rate of people who commit violent acts.

THE DEFINITION OF DANGEROUSNESS

Currently, the element of dangerousness is considered at every stage in the criminal justice and mental health systems including bail, preventive detention, sentencing, release and involuntary civil commitment. But even though the concept of dangerousness is central to some of the most important decisions (in the view of the individual as well as society), there is no generally accepted definition of the term.

The ambiguity of the concept in the absence of an agreed upon definition precludes the accomplishment of solid research. A person may be (and has been) labeled dangerous for everything from mismanagement of personal finances to mass murder. The term "dangerousness" is thus used to describe both very violent and relatively minor non-violent actions. The vague definitions do not distinguish among menace, nuisance, assaultive, or violent dangerous and deviant behavior (Brooks, 1979).

Such definitions usually:

1. Reflect a person's ideosyncratic legal views, as well as his or her personal values concerning the protection of society (Brooks, 1979);

2. Tend to characterize all deviant behaviors of mentally ill persons as dangerous (Brooks, 1979);

3. Include all crimes as well as certain crimes designated as violent, harmful or having maximum sentences, any conduct which may provoke retaliatory acts, any violent harmful or threatening conduct, etc. (This study is briefly discussed in Levine, 1977); and

4. Depend upon one's theory of what produces or eliminates dangerous behavior (Schwitzgebel, 1979).

A number of studies have recommended various definitions of dangerousness:

Cohen (1978): a person having a high probability of inflicting serious bodily injury on another.

Dix (1976): as physically, assaultive behavior directed at self or others.

Levine (1977): one where the accused is convicted of an offense involving physical harm and has a substantial likelihood that one, if at large, will commit acts causing or threatening physical harm to others.

Megargee (1976): acts characterized by the application or overt threat of force which is likely to result in injury to people.

Schlesinger (1978): those behaviors resulting in harm to self or others.

Scott : a violent behavior with violence defined as aggression concentrated into a brief span of time which is not necessarily more destructive than continued aggression of lesser intensity.

Shah: as a propensity to engage in acts that are characterized by applying or overtly threatening force and are likely to result in injury to others and as synonymous with violent behavior.

Thornberry: any criminal offense involving physical injury to others.

Studies conducted by Shah, Schwitzgebel and Jacoby suggest that there may be dangerous or violent settings which also should be considered in defining dangerousness.

Problems arising from the inability to develop a generally applicable definition include distinguishing legal/illegal violent acts:

> The working definition of violence adopted by the National Commission on the Causes and Prevention of Violence ... was 'overtly threatened or overtly accomplished application of force which results in the injury or destruction of persons or property or reputation, or the illegal appropriation of property.' ...such a definition would include as violent: accidental homicide, homicide in self defense, or injury on the football field. ...the two issues confound the framing of a completely acceptable definition of violence. The first of these is legality. By ignoring legality and focusing on the act itself, the Commission has unwittingly characterized as violent various legal injuries to people. The alternative of defining violence in terms of illegal acts, however, 'is to classify as nonviolent the behavior of Nazi genocidists or Roman gladiators...' The second nemesis of obtaining an acceptable definition of violence is the question of intentionality. The Commission's definition includes unintentional or accidental violence. The alternative of specifying that violence can only be intentional or conscious would not hold well with those of psychoanalytic bent. (Monahan, 1981:4)

The definitional problems are reflected in evidentiary requirements for a finding of dangerousness. Expert testimony is accepted by some courts; others require evidence of a recent act or threat of violence. There is a trend, however, in case law toward the requirement for a clear, unequivocal and convincing evidence of dangerousness.

The more stringent evidentiary requirements often lead to conflict between the courts and the psychiatrists. The courts, in addition to recognizing the psychiatrists' inability to predict violence, may also recognize their tendency to manipulate the dangerousness concept in order to accomplish treatment objectives for the patient (Brooks, 1979). Psychiatrists, on the other hand, may base their assessment on psychological factors and are very resentful when courts release patients against their professional judgment.

Another negative effect of ambiguity is that in the absence of specific commitment criteria, public pressure for commitment of "dangerous" persons, as well as the threat of personal liability for violent acts committed by persons released as not dangerous, creates a tendency for mental health professionals to make "safe" decisions to commit.

These problems will be very difficult to overcome, and there is a consensus in the literature that before moral, legal and empirical progress can be made in the prediction of dangerous behavior, the predictors must be specific about what they are predicting and how they go about predicting it:

> This involves explicitly enumerating the kinds of acts one takes to be violent, frankly stating the factors on which prediction is based, and being clear on the likelihood with which it is believed they will occur. One's judgment on all these factors may vary with the purpose to which the prediction is put. (Monahan, 1981:40)

PREDICTING DANGEROUS BEHAVIOR

Is mental illness a predictor of dangerousness? We still don't know. Some studies find that it is; others find it is not. In all societies, the mentally ill person has been perceived as a threat, and some means of protecting the public has been institutionalized. In the early renaissance period, the mad were set afloat in a "ship of fools" and were allowed to come into harbor only for replenishing supplies. In the 17th century, all kinds of socially undesirable people were locked up together in prison. There was no differentiation between the insane, the criminal, the impoverished, the mentally deficient, the handicapped, or the corrupt.

Although there have been significant changes in the means used to protect society from the threat posed by the mentally ill, the irrational fear and the stigma of mental illness remain. The fear affects us all. Mental health workers complain that the police believe anyone who acts a little "weird" is dangerous. This has been the basis for mental health professionals' objections to associating dangerousness with mental illness and the impetus for a great deal of research which explores the relationship between mental illness and violent behavior.

A number of these studies have compared recidivism rates of mental patients to those of criminal offenders or, more rarely, of the general population (Jacoby, 1976). The Leshley (1922), Pollack (1938), Cohen and Freeman (1944), and Brill and Malzbert (1947, as cited in the Shah study) found lower arrest rates among mental patients than the general population. Other studies, i.e. Rappeport and Larsen (1954), Giovanni and Gurel (1967), Petrin (1976), and Shah (1978), found somewhat higher arrest rates among mental patients than general population.

It is interesting to note that studies performed in the 1960s and 1970s have consistently found a higher rate of violent behavior among former patients than among the general population, while earlier studies found a lower rate of arrest for violent behavior (Monahan, 1981). The researchers attribute this finding to "the changing clientele of state hospitals." When previous arrests were considered, it was found that mental patients

with no previous arrest record have a lower arrest rate than the general population, while patients with one arrest prior to hospitalization have a slightly higher than average arrest rate (except for sex crimes, which are much higher), and patients with two or more arrests have a "drastically higher violent crime rate than the general population" (Monahan, 1981:116).

Thus, the higher rate of violent crime committed by released mental patients is explained by an increase in the number of mental patients with criminal histories. (Of course, deinstitutionalization may be responsible for the increase in the crime among mental patients.) For both criminals and the mentally ill, the best predictor of future violence is past violence.

The disparity between these two groups of studies which found higher, or conversely, lower arrest rates among the mentally ill may be the result of methodological problems. A small list of the problems noted in the literature follows (Jacoby, 1979):

- using arrest as an indicator of violence
- using incomplete arrest records or limited data accessibility
- omitting out of state arrests
- omitting violent incidents
- failing to account for a decrease in the amount of time the patient was at risk, i.e. rearrest or hospitalization while computing annual arrest rates
- the nonrepresentativeness of mental hospital patients to all mentally ill persons in the population
- the demographic characteristic differences between the mentally ill and the general population

All the factors previously discussed affect the ability to predict violent behavior accurately. Even the most common behavior is difficult to predict, but when a behavior is as relatively rare as violence, it becomes almost impossible. This is about the only issue in this area on which there is consensus.

Some fairly recent studies predicting dangerousness have attempted to validate the reliability of certain predictors. These studies usually compare personality characteristics based on clinical judgments made by mental health professionals to violent behavior (McGurk, 1978; Heilbrum, 1979; Jacoby, 1976; Wright and Miller, 1977). Other research has assessed reliability of predictions by:

- comparing frequencies of violent and nonviolent behavior among mentally ill patients in a maximum security or civil mental hospital (Jacoby, 1976)
- looking at arrest rates of former mentally ill patients who have been discharged (Jacoby, 1976; Jacoby, 1978; Shah, 1978)
- predicting of post discharge offenses (Monahan, 1978; Jacoby, 1976)

One of the major problems is the low base rate of violent behavior. The base rate is the frequency with which violence is committed in a given time

period. It has been long understood that low base rate events cannot be predicted without misidentifying many "false positives":

> Assume that one person out of a thousand will kill. Assume also that an exceptionally accurate test is created which differentiates with 95 percent effectiveness who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill, 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. (Livermore, et al, 1968:84)

Monahan goes on to say that the "best" population on which to apply clinical predictors of violence is one with a base rate of 50 percent:

> As the base rate differs substantially from 50 percent, clinical differentiation becomes progressively more difficult. If 90 percent of a group will be nonviolent, the best prediction in the individual case is to predict them all nonviolent. (1981:60)

Other factors affecting accurate prediction include subjectivity, failure to consider environmental factors, and different time frames. The bias (or selective perception) which leads individuals to see relationships they deem appropriate to the situation has been well documented in research (Monahan, 1981). A "gut feeling" that an individual is dangerous creates the tendency for the professional to perceive the actions of the individual as indicators of dangerousness. Also, certain attributes of the individual may inspire the feeling that the patient is dangerous.

Environmental factors are often neglected. In the prediction of violent behavior, two things are being predicted: the personality of an individual, and the interaction between that personality and a certain environment.

> Clinical data show clearly that a person evaluated as high risk based on prerelease data may well be a false positive error if environmental factors are not included in the prediction. If the released offender enters a stable, supportive home in a concerned community, and undertakes a self-selected job that provides financial support and personal gratification, his high risk evaluation may be inaccurate. (Cohen, Groth and Siegel, 1978:33)

On the other hand, if these social supports do not exist, and the patient returns to a situation of poverty, distrust and lack of medical or psychiatric care, then a prediction that the patient will not be dangerous may also be inaccurate.

Thus, Monahan and others conclude that "it is the relative absence of current knowledge about the exact environmental conditions that are operating in the community context in which the individuals will be functioning which relegates long term institutional predictions to the realm of whimsey" (Monahan, 1981:90).

Other important considerations in accuracy of prediction are context and time frame. Monahan identifies the following differences between emergency commitment and long term institutional predictions:

1. The context of prediction is the same as the context of validation. A prediction is being made in the open community that a person will be violent in the same context.

2. The time between the point of prediction and the validation period is very short.

3. Since the prediction is being made in the same context in which it will be validated, there is little time intervening between the most recent exposure to the context of validation and the point of prediction. The prediction is made immediately after observing how the person behaves in the context in which the prediction would be validated. The information available to the predictor is thus fresh and current.

The general conclusion found in the literature is that no more than one in three predictions of violent behavior is accurate. Several recommendations have been made for improving the accuracy and usefulness of predictions of violence. For example, Bem and Funder (1978) recommend that three questions be asked:

1. What characteristics describe the situations in which the person reacts violently?

2. What characteristics describe the situations which the person will confront in the future?

3. How similar are the situations the person will confront in the future to those that have elicited violence in the past?

To summarize the foregoing review, in the last decade social and political changes led to the release of thousands of mentally ill patients from mental hospitals, and to the development of a body of patients' rights laws. The laws have narrowed the criteria for involuntary commitment, allowing commitment only for those who are mentally ill and dangerous to self, dangerous to others, or gravely disabled. The law also prohibits confinement without treatment, treatment without consent, and mandates confidentiality of patient records.

The more narrow commitment criterion of dangerousness has placed mental health professionals in an untenable position: they are asked by the court, and by the state, to assess dangerousness when, in fact, this is not possible given the state of the art.

Colorado courts have ruled on several of these issues. Their interpretations are summarized in the following section.

PERTINENT COLORADO CASE LAW

LONG TERM TREATMENT; SUFFICIENCY OF EVIDENCE

In People v. Lane, Colo, 581 P.2d 719 (1978), the issue before the court was whether the evidence adduced in court constitued "clear and convincing evidence" of dangerousness sufficient to justify long term confinement pursuant to section 27-10-109, CRS 1973 (1976 Supp).

In construing section 27-10-109 and section 27-10-111 (hearing procedures), the court held that before authorizing long term commitment, the trial court must find, not only that the patient is mentally ill, but also as a result of his illness that he is either: (1) a danger to others, (2) a danger to himself, or (3) gravely disabled. Because the deprivation of liberty is at stake, evidence in support of confinement must be carefully scrutinized and must constitute "clear and convincing evidence" of dangerousness --- "that evidence which is stronger than a 'preponderance of the evidence' and which is unmistakable and free from serious or substantial doubt."

The court held that the uncorroborated testimony of the patient's treating psychiatrist, setting forth a continuous series of aggressive and assaultive behavior, from 1955 until 1975, constituted clear and convincing evidence of the patient's future dangerousness to others as a result of his mental illness.

STANDARDS FOR RELEASE, NGRI; FUTURE DANGEROUSNESS

In People v. Howell, 196 Colo 408, 586 P2d 27 (1978), Howell appealed the denial of his release from the Colorado State Hospital claiming that the statutory standard governing eligibility for conditional release violated his right to due process of law.

Howell was committed in 1971 to the state hospital from a finding of not guilty by reason of insanity to the charge of murder. Two years later he was again found not guilty by reason of insanity in the murder of a hospital employee, and was then confined at the state penitentiary as a state hospital patient. Except for a brief return to the state hospital, he remained in the maximum security section of the penitentiary until the time of the complained of release hearing.

At his 1977 release hearing trial, Howell testified that he believed he was no longer violent and could control himself in the future. In contrast, seven psychiatrists, four psychologists and three social workers all testified that he was dangerous, having a sociopathic personality with chronic antisocial aggressive tendencies. Howell's past behavior was the most important factor upon which predictions of future dangerousness were based.

Evidence indicated that Howell, at age 13, had beaten a boy with a baseball bat, and left him in a field to die' that he had shot another man four to five times; that he had shot his common law wife in the legs; that he had been convicted of six aggravated robberies and two assaults with deadly

weapons and had served time in the reformatory and penitentiary for these convictions. In 1970 Howell had walked into a crowded bar, ordered a drink and then shot the bartender five times. For this killing he had been committed to the state hospital. In his first two years at the hospital he threatened employees and assaulted a patient, for which he was removed to the hospital's maximum security ward. In 1972 he cornered two hospital employees and threatened them with a knife. A third employee intervened, and Howell slashed his throat, killing him. Again he was found not guilty by reason of insanity, and was transferred to the maximum security division of the state penitentiary for "safekeeping."

From 1973 to 1976, his aggressive behavior continued: threats against hospital employees; throwing glass at guards; maintaining a vengeance list including hospital employees and a district court judge; and, claims of the commission of another murder.

Another factor considered in the diagnosis and opinion of future dangerousness was Howell's "affect", or inappropriate responses. For example, Howell stated that he was sorry for the death of the hospital employee, yet he was smiling when he made the statement.

The third factor contributing to the unanimous opinion was the fact that "a sociopathic personality disorder is usually a lifelong, chronic problem with successful treatment having been reported rarely." Although therapy may have helped Howell, he often refused therapy.

Howell did not challenge the facts or conclusions, but argued that section 16-8-120 was vague and unconstitutional, and that evidence of "more recent" acts must be required to predict future dangerousness. The Supreme Court rejected his contentions, finding section 16-8-120 constitutional on its face. The court further held that the absence of "recent" overt acts "may only reflect successful restraint by the institution and may be no indication of the patient's lack of dangerousness if released from that environment. Thus, it would be illogical to base a conclusion regarding a confined patient's likely dangerousness if released to an open society on his recent behavior, for he has no recent opportunity to react to the temptations and opportunities for aggression offered by an open society."

Howell finally argued that section 16-8-115 constituted a denial of due process by placing the burden of proof on him rather than on the proponents of continued institutionalization. The court also found this contention to be without merit.

COMMITMENT PROCEEDINGS; DETERMINATION OF VOLUNTARINESS

In Sisneros v. District Court, Tenth Judicial District, Colo, 606 P.2d 55 (1980), the Supreme Court reversed the lower court's order certifying the petitioner for short term treatment. In construing section 27-10-107, CRS 1973, as amended, the court stated:

> The language of this section is plain, and its meaning is clear. A two-step inquiry must precede short term certification under section 27-10-107. First, it must be

determined whether the person whose certification is sought has been advised of the availability of voluntary treatment for his or her asserted mental illness. If the advisement has not been given, short term certification is precluded. Second, assuming that a proper advisement has been given, it must be determined whether the person whose certification is sought has or has not accepted voluntary treatment, and, further, whether there exist reasonable grounds to believe that the person will not remain in a voluntary treatment program which he or she has accepted. If voluntary treatment has been accepted, and if reasonable grounds exist to believe that the person will remain in a voluntary treatment program, certification is precluded.

In this case, the lower court exceeded its jurisdiction in ordering short term certification because the jury had determined that Sisneros had not been properly advised of the availability of voluntary treatment. Citing Barber v. People, 127 Colo 90, 254 P.2d 431 (1953), the court stated that because of the curtailment of personal liberty which results from certification, "strict adherence to the procedural requirements of the civil commitment statute is required."

EMERGENCY PROCEDURES; PROBABLE CAUSE

In People in the Interest of Paiz, Colo App, 603 P2d 976 (1979), the patient appealed the denial of her motion to dismiss proceedings under the statutes governing treatment of the mentally ill. The facts in this case indicate that the patient sought voluntary treatment as a patient at the Colorado State Hospital. Thereafter, she was taken into custody for 72 hour treatment and evaluation by a physician of the hospital pursuant to the emergency procedure set forth in section 27-10-105(1)(a), CRS 1973, as amended. An emergency mental illness report was prepared by the physician and filed with the court, pursuant to section 27-10-105(1)(a), CRS 1973, as amended. The physician's report evidences that he was notified of the patient's condition by the team leader of the hospital ward where the patient was being treated, and also reflected that the patient had received psychiatric care at the hospital at some time prior to her voluntary hospitalization. The report noted that the patient was tense, illogical, mumbling, and hearing voices; that she appeared to be mentally ill, and as a result, gravely disabled because she was unable to regulate her diabetic diet or medication; that she had no money nor any place to go, but was requesting that she be allowed to return to her own apartment, which had been forfeited; that she had little insight into her problems and required 24-hour supervision.

The hospital subsequently filed a request for extended certification of short-term treatment, alleging that the patient was schizophrenic, mentally

retarded, diabetic and required daily insulin which she would not self administer; that she was pregnant, and previous children were in foster care due to neglect; that she tried to break windows in the ward, and had threatened to kill employees; and that she refused to cooperate with her physicians.

The patient was subsequently committed for long-term treatment, and although she had refused to participate in any of the hearings, through court-appointed counsel she had filed motions to dismiss all proceedings, which were denied.

On appeal the Supreme Court addressed the following points: whether a voluntary patient could be subject to the emrgency provisions of section 27-10-105(1)(a); and, whether subsequent to the 72-hour evaluation, probable cause was established to support further proceedings. The court ruled against the patient on both issues.

First, in reference to the 72-hour emergency procedure, the court held that the plain language of the statute does not preclude emergency procedures involving voluntary patients, stating: "A patient admitted for voluntary treatment who obviously has become a serious danger to himself or to others might have to be released from the hospital pending the completion of court proceedings pursuant to §27-10-105(1)(b) or §27-10-106. We conclude that confinement for 72-hour evaluation pursuant to §27-10-105(1)(a) was proper."

Second, the patient's contention that all subsequent proceedings were invalid for failure to establish probable cause was also rejected, the court stating:

> "Probably cause exists under the statutue for a licensed physician to take a patient into custody for a 72-hour evaluation when the facts and circumstances within the physician's knowledge and of which he has reasonably trustworthy information from others warrant the belief that the patient may be gravely disabled. (Citation omitted.) And, as one of its dimensions, the physician's training and experience may be considered. (Citations omitted.) Thus, we find no merit in respondent's contention that the veracity of the ward team leader must be established by information in the report."

RIGHT TO REFUSE TREATMENT

In Goedecke v. State, Department of Institutions, Colo., 603 P. 2d 123 (1979), the patient appealed the district court's order holding that a mental health center could administer an anti-psychotic drug to the patient in spite of his objections. Goedecke was certified for short-term treatment pursuant to section 27-10-107, CRS 1973, as amended, having been diagnosed as a paranoid schizophrenic. He was determined to be dangerous on the basis of misdemeanor assault charges and verbal threats against a judge and others. At the certification hearing, a psychiatrist testified that the patient would be confined for up to three weeks, and would be treated with prolixin thereafter on an outpatient basis to alter his psychotic thought patterns and to minimize his dangerousness.

The patient adduced expert testimony of the negative side effects of the drug, and that he had suffered such side effects from previous treatments. The district court ruled that the mental health center could administer the drug despite the patient's objections.

The Supreme Court reversed the lower court's ruling, relying on the legislative intent set forth in section 27-10-101(1)(c), (1)(d), and section 27-10-104, which states that: "Unless specifically stated in an order by the court, a respondent shall not forfeit any legal right or suffer legal disability by reason of the provisions of this article." The court further stated that the patient's common law right to decline treatment is preserved by section 27-10-104, and cannot be abrogated in the absence of "some finding, reached by a competent tribunal, that the patient's illness has so impaired his judgment that he is incapable of participating in decisions affecting his health."

LIABILITY FOR RELEASE DECISION

In Brown v. Rosenbloom and Province, Colo. App., 534 P.2d 626 (1974), on certiorari, Province v. Brown; Rosenbloom v. Brown, Colo., 532 P.2d 948 (1975), the appellate courts considered the question of whether physicians appointed by the court as a medical commission to determine the sanity of one Culver Murray were liable for damages due to negligence. Although the case turns upon the interpretation of a statute since repealed, the discussion is pertinent to the issue of quasi-judicial immunity.

The facts of the case show that Culver Murray had been incarcerated in the state penitentiary on charges of, inter alia, assault to commit rape. Murray became eligible for release, and the deputy warden requested that a determination be made as to Murray's sanity. The district court appointed two doctors as a medical commission to examine his sanity. After a hearing, the doctors found Murray legally sane and recommended discharge.

Within a year of Murray's discharge, he allegedly murdered two women and assaulted two others, including Ms. Brown. In her suit she charged that the doctors failed to use reasonable care in their diagnosis and evaluation of Murray, resulting in his release and subsequent violent acts.

The doctors, Rosenbloom and Province, denied all negligence, and further argued that having acted in good faith under a court order as a medical commission, they were immune from civil liability because of section 27-9-122, CRS 1973 (repealed, 1975), which provided in pertinent part:

> "Actions barred. No person, acting in good faith under any order of the court directing that respondent be . . . held for. . . examination (and) diagnosis. . . and not acting in violation or abuse thereof, shall be liable for such action. . ."

Finding no Colorado case on point, the Colorado Supreme Court elected to "follow the trend in other jurisdictions "that apply immunity from civil

liability to persons acting in a quasi-judicial capability. Thus, the court found that the doctors, acting in good faith and without violation or abuse of the court order, were entitled to the immunity set forth in section 27-9-122.

RECOMMITMENT UNDER NGRI; CONDITIONS FOR RELEASE

In Campbell v. District Court, 195 Colo. 304, 577 P.2d 1096 (1978), petitioner Cambell challenged the trial court's authority to recommit. Campbell had been institutionalized at the Colorado State Hospital subsequent to a finding of not guilty by reason of insanity of assault with a deadly weapon, assault upon a police officer, and attempted murder. After two years he was found eligible for release, and the trial court imposed conditions on his release pursuant to section 16-8-115(3). The conditions included outpatient therapy, frequent contact with the court and the state hospital concerning his progress, and that "the defendant shall not at any time possess firearms of any kind."

Campbell was subsequently taken into custody for possessing a sawed-off rifle. Due to the alleged breach of his conditional release, a hearing was held to determine whether Campbell should be recommitted. Thereafter the court determined that Campbell had "an abnormal mental condition which would be likely to cause him to be dangerous either to himself or to others or to the community in the reasonably forseeable future."

Campbell argued that no condition commonly imposed in criminal probational proceedings can constitutionally be imposed upon persons found not guilty by reason of insanity. In reviewing the conditions imposed upon Campbell's release, the Supreme Court found that each condition bore a substantial relation to the petitioner, and were tailored to serve the best interests of the petitioner and the community. Although the restriction against possessing firearms is often a condition placed upon probationers, such restriction was ruled to be particularly applicable in this case due to petitoner's criminal history. Thus, the court held that "a release condition of this nature is not unconstitutional if it bears a relationship to the particular indiviudal seeking release and is in the best interests of the defendant and community."

Campbell further argued that the trial court exceeded its jurisdiction because there is no statutory language authorizing the court to order recommitment. This contention was disposed of as follows: "The statutory authority to issue a conditional release order necessarily and implicitly includes the authority to enforce that order by recommitment."

CIVIL AND CRIMINAL COMMITMENT STATUTES

Colorado has two main statutes under which the mentally ill may be involuntarily committed for observation and/or treatment. The Mental Health Statute, CRS 27-10, 1973 and the Criminal Insanity Statute, 16-8, 1973 are summarized in the following pages and a flow chart of the civil and criminal commitment process is presented at the end of this section.

As specified by the legislature, the intent of CRS 27-10 is as follows:

> "(a) To secure for each person who may be mentally ill such care and treatment as will be suited to the needs of the person to insure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;
>
> (b) To deprive a person of his liberty for purposes of treatment or care only when less restrictive alternatives are unavailable and only when his safety or the safety of others is endangered;
>
> (c) To provide the fullest possible measure of privacy, dignity, and other rights to persons undergoing care and treatment for mental illness;
>
> (d) To encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness."

Colorado law further recognizes that a patient will not forfeit any legal right or suffer any legal disability by reason of these provisions, absent an order of the court (§27-10-104). Definitions applicable to these provisions are set forth in §27-10-102, and include the following pertinent definitions:

> "' Mentally ill person' means a person who is of such mental condition that he is in need of medical supervision, treatment, care, or restraint." §27-1-102(7).
>
> 'Gravely disabled' means a condition in which a person, as a result of mental illness, is unable to take care of his basic personal needs or is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so. A person of any age may be 'gravely disabled' under this definition, but the term does not include mentally retarded persons by reason of such retardation alone."

Pursuant to section 27-10-106, the court may, upon petition, order the evaluation of a person alleged to be mentally ill, who, as a result of such mental illness, is a danger to others or to himself, or is gravely disabled. If the petition meets the statutory requirements for sufficiency, the court must designate a facility approved by the executive director, or request that a specified professional screen the person to determine whether probable cause exists to believe the allegations. If probable cause is found, the person must be given an opportunity to accept further evaluation voluntarily. If he refuses, the court must order the person taken into custody and placed in a facility to designated by the executive director for 72-hour treatment and evaluation. The screening report establishing probable cause remains confidential pursuant to section

27-10-120. Following 72 hours, the person must be released, referred for further treatment and care on a voluntary basis, or certified for short-term treatment.

Section 271-10-105 provides for emergency situations where the 72-hour treatment and evaluation may be conducted absent a prior professional evaluation establishing probable cause. Such an emergency, however, must be established by showing either that the peace officer or professional person taking the person into custody had probably cause, or that by sworn affidavit before a judge, probable cause was shown that as a result of mental illness, the person appeared to be a danger to others or to himself, or appeared to be gravely disabled.

In all situations, the person must be given the opportunity to accept or refuse voluntary treatment. Further, pursuant to section 27-10-103, any person may voluntarily seek treatment at any time, maintaining all the rights and privileges of any hospitalized patient. The medical and legal status of all voluntary patients receiving treatment for mental illness in inpatient or custodial facilities must be reviewed at least every six months.

If, following the 72-hour evaluation and treatment provided for by sections 27-10-105 and 106, the person is certified for short-term treatment (three months) - having either refused treatment voluntarily or accepted voluntary treatment, but reasonable grounds exist to believe that he would not remain in a voluntary treatment program - the person or his attorney may request outpatient status, or request that the certification or the treatment be reviewed by the court. The hearing must be had within 10 days of the request, and the burden of proof is upon the party seeking to detain. Following the hearing, the court may enter or confirm the certification for short-term treatment, discharge the person, or enter any other appropriate order (§27-10-107,111).

An additional three month short-term request for treatment may be granted by the court upon application in compliance with section 27-10-108. The patient has the same legal rights at an extension hearing as in the original proceeding for certification. Once a patient has received short-term treatment for five consecutive months, the professional in charge may petition the court for long-term care. The petition must allege that the patient continues to be mentally ill and a danger to others or to himself, or gravely disabled; that the patient continues in his refusal to accept voluntary treatment or having accepted voluntary treatment, reasonable grounds exist to believe that he would not remain in a voluntary treatment program; and, that the facility which will provide long-term care and treatment has been designated or approved by the executive director to provide such care and treatment. Upon the basis of such application, the patient may request a hearing on the issue. Should the court find just cause to grant the application, another hearing must be set prior to the

expiration of the six-month period set forth in section 27-10-109. The court may entertain a request for imposition of a legal disability or the deprivation of a legal right when long-term treatment is reqeusted.

Further extensions for treatment and care must conform to the procedural requirements of section 27-10-109. All treatments shall terminate under sections 27-10-107, 108, and 109 upon notice by the professional person in charge of the treatment that the patient has received sufficient benefit from such treatment for him to leave. Such notice shall be given the court in writing within five days of such termination. The professional person may prescribe day care, night care, or any other similar mode of treatment prior to termination.

A patient has the right to a jury determination on the issues of whether short-term or long-term treatment is required, or on any requests for extensions thereof. He has the right to appeal or apply for habeas corpus relief upon the basis of any order for short-term or long-term treatment or care, and may have a civil cause of action upon the charge and proof of discrimination due to his status. (§§27-10-111,112,113,115.)

In addition, the patient has the right to psychiatric care and treatment suitable to his needs, and provided in such manner as to keep him in the least restrictive environment possible. He may petition for habeas corpus relief for release to a less restrictive setting within or without a treating facility, or for release when adequate medical or psychiatric treatment is not being administered. The department is required to adopt rules and regulations to assure that each agency or facility providing evaluation, care, or treatment requires: (1) consent for specific therapies and medical treatment (the nature of the consent, by whom it is given and under what conditions, shall be governed by departmental regulations); (2) the order of a physician for any treatment or specific therapy based on appropriate medical examinations; (3) Notations in the patients' treatment record of periodic examinations, evaluations, orders for treatment, and specific therapies signed by the personnel inolved; and, (4) Conduct, according to the guidelines contained in the regulations of the federal government and the department with regard to clinical investigations, research, experimentation, and testing of any kind. (§27-10-116.)

Section 27-10-120 requires that all information obtained and records prepared in the course of providing services to patients must be confidential and privileged matter, and that information and records may be disclosed only: (1) In communications between qualified professional persons in the provisions of services or appropriate referrals; (2) to designees of the patient, his guardian, or conservator; (3) where necessary, in making claims on behalf of the patient; (4) for research, if the department promulgates rules for the conduct of such research (which has not been done according to the May 30, 1978, Rules and Regulations governing "Care and Treatment of the Mentally Ill"); (5) to the courts in the administration of justice; and, (6) to persons authorized by the court following notice and an opportunity for a hearing to the patient and the custodian of the record

or information. Senate Bill 100, enacted May 18, 1981, further excepts observed behavior which is a crime committed upon the premises of a state institution or against a person performing or receiving certain services from this privilege; and, article III(b), section 24-60-1001 of the Interstate Compact on Mental Health requires inclusion of the patient's full record in a request for transfer for mental care and treatment.

INSANITY/NGRI (SECTION 16-8-101 et.seq., CRS, 1973)

The plea of not guilty by reason of insanity (NGRI) is an admission to the crime charged, but a denial of culpability by reason of insanity. The applicable test for insanity is: "A person who is so diseased or defective in mind at the time of the commission of the act as to be incapable of distinguishing right from wrong with respect to the act, or being able so to distinguish, has suffered such an impairment of mind by disease or defect as to destroy the willpower and render him incapable of choosing the right and regaining from doing the wrong is not accountable; and this is so howsoever such insanity may be manifested, by irresistible impulse or otherwise. But care should be taken not to confuse such mental disease or defect with moral obliquity, mental depravity, or passion growing out of anger, revenge, hatred, or other motives, and kindred evil conditions, for when the act is induced by any of these causes the person is accountable to the law." (§16-8-101, CRS, 1973)

Upon entry of such plea or evidence that such plea may be appropriate (§16-8-103), the court shall order a sanity examination pursuant to section 16-8-105. The examination shall be accomplished by committing the defendant to the Colorado psychiatric hospital in Denver, the state hosptial in Pueblo, the place where he is in custody, or such other public institution designated by the court. The defendant shall be observed and examined by one or more physicians who are specialists in nervous and mental diseases during such period as the court directs. The court may order such further or other examinations, including services or psychologists, as is advisable under the circumstances, and the defendant may procure the psychiatric examiner of his own choice.

Utilization of certain drugs and a polygraph examination include: the names of the physicians or experts who examined the defendant; a description of the nature, content, extent and results of the examination and any tests conducted; a diagnosis and prognosis of the defendant's physical and mental disease or defect, if any; and, separate opinions as to whether the defendant was insane at the time of the act. (§16-8-106.)

Upon receipt of the sanity examination report, the court must set the issue of insanity for trial. At trial the defendant is presumed to be sane, but once any evidence of insanity is introduced, the prosectuion has the burden of proving sanity beyond a reasonable doubt. If the defendant is found to be sane, the court sets the matter for trial on the defendant's plea of not guilty. If the sanity trial results in a verdict of insanity (NGRI), the court must commit the defendant to the Department of Institutions until

such time as he is eligible for release (§16-8-105). A verdict of not guilty by reason of insanity is tantamount to a verdict of not guilty, and the defendant is not a convicted criminal. Scheidt v. Meredith, 307 F. Supp. 63 (D.Colo., 1970).

Evidence obtained as a result of the sanity examination may not be used to incriminate the defendant, but is admissible solely upon the issue of sanity (§§16-8-106, 107). However, if the defendant is found to have been sane at the time he committed the act, evidence obtained as a result of the sanity examination can be introduced at the trial on the merits of his not guilty plea once the defense of diminished capacity has been raised, and then may be considered only as to the issue of whether defendant possessed the requisite intent to commit the crime charged (§16-8-107).

If a defendant has been committed to the Department of Institutions subsequent to a finding of NGRI, the court may order a release hearing at any time on its own motion, motion of the prosecuting attorney, motion of the defendant, upon the contested report of the chief officer of the institution in which the defendant is committed (see §16-8-116), or upon motion of the defendant within 180 days following his commitment. If the questions of eligibility for release is contested, the court may order a release examination or any further examinations which it deems appropriate. At the release hearing, the burden of proof is on the party contesting the report of the chief officer having custody of the defendant (§§16-8-115, 116). The applicable test for release is "That the defendant has no abnormal mental condition which would be likely to cause him to be dangerous either to himself or to others or to the community in the reasonably foreseeable future." (16-8-120.)

A hearing is not required if, pursuant to section 16-8-116, the report of the chief officer of the institution in which the defendant is committed and recommendations contained therein are uncontested. If the court (or jury) finds that the defendant is eligible for release, the court may impose such terms and conditions as the court determines are in the best interests of the defendant and the community. If the finding is that the defendant is ineligible fo release, the court must recommit the defendant. Thus, for purposes of this section, a commitment pursuant to a finding of NGRI may be for an indefinite period of time.

INCOMPETENCY (SECTION 16-8-102 et. seq. CRS, 1973)

Incompetency to proceed in a criminal matter may be raised at any time by any interested party (§16-8-110). " 'Incompetent to proceed' means the defendant is suffering from a mental disease or defect which renders him incapable of understanding the nature and course of the proceedings against him or of participating or assisting in his defense or cooperating with his defense counsel." (16-8-202(3). 'Insanity' and 'incompetency' are distinct issues: 'insanity' is substantive in nature because the defendant's mental condition at the time he committed the crime may render him not guilty, is procedural in nature and reaches constitutional propor-

tions because a defendant, in order to be tried, must be able to assist with his own defense and understand the nature of the proceedings. Where a finding of 'insanity' renders the defendant not guilty of the crime charged, a finding of 'incompetency' merely abates the proceedings. People v. Gillings, Colo. App., 568 P.2d 92 (1977).

Once the issue of incompetency has been raised, all criminal proceedings must be suspended, and if a jury was impaneled and sworn, a mistrial may be declared (16-8-111). If the final determination is that the defendant is incompetent to proceed, the court shall order the defendant committed to the Department of Institutions until such time as he is found competent. The executive director of the Department of Institutions has the same powers with respect to a commitment pursuant to a finding of incompetency as he does following a finding of NGRI (§16-8-112).

The court may order a restoration to competency hearing at any time, on its own motion, motion of the prosecution, or upon motion of the defendant. The court must order a hearing if the head of the institution to which the defendant was committed files a report stating that the defendant is mentally competent to proceed or if the treating physician files a report certifying that the defendant is mentally competent to proceed. If the issue is contested, the burden of proof is upon the party asserting competency (§16-8-113).

Upon a finding that the defendant has been restored to competency pusuant to section 16-8-114, or upon an initial finding of competency pursuant to section 16-8-112, the criminal proceedings are resumed. If the court determines that the defendant remains incompetent to proceed, he may continue or modify any orders entered at the time of the original determination of incompetency any may commit or recommit the defendant, or enter any new order necessary to facilitate the defendant's restoration to competency. The court must credit any time that the defendant spent in confinement while committed upon a finding of incompetency to any term of imprisonment imposed following restoration to competency, and subsequent conviction (§16-8-114).

NEW LEGISLATION

In the last legislative session, Senate Bill 1 and House Bill 1281 enacted several changes to the criminal insanity statutes. These are summarized below.

Senate Bill 1

This bill revises the criminal statutes of 16-8-102, 16-8-115.5 and 16-8-115 to provide for the conditional release of persons who are not guilty by reason of insanity. Its effective date is July 1, 1981. The amendments include:

1. Statutory authority for revocation of conditional release.
2. Definitions of persons ineligible to remain on conditional release.
3. Procedures for conditional release and revocation of conditional release.
4. Assigned supervisory responsibility to treating facilities for persons placed on conditional release.

5. Treating facilities to prepare quarterly reports on treatment and status of conditionally released persons for the District Attorney and the Department of Institutions.

6. Free exchange of client information between the Department of Institutions, community mental health centers, district attorneys, law enforcement and court personnel, as long as the person is on conditional release.

House Bill 1281

This bill revises criminal statutes 16-8-112 and 16-8-114.5 regarding persons who are incompetent to proceed. Its effective date is January 1, 1982. The amendments include:

1. Incompetent-to-proceed defendants may receive treatment on an outpatient basis, if the psychiatric evaluation indicates it is desirable and the alleged offense does not involve violent behavior.

2. Incompetent-to-proceed defendants are eligible for bond.

3. Court proceedings may continue if a defendant is found to be incompetent to proceed.

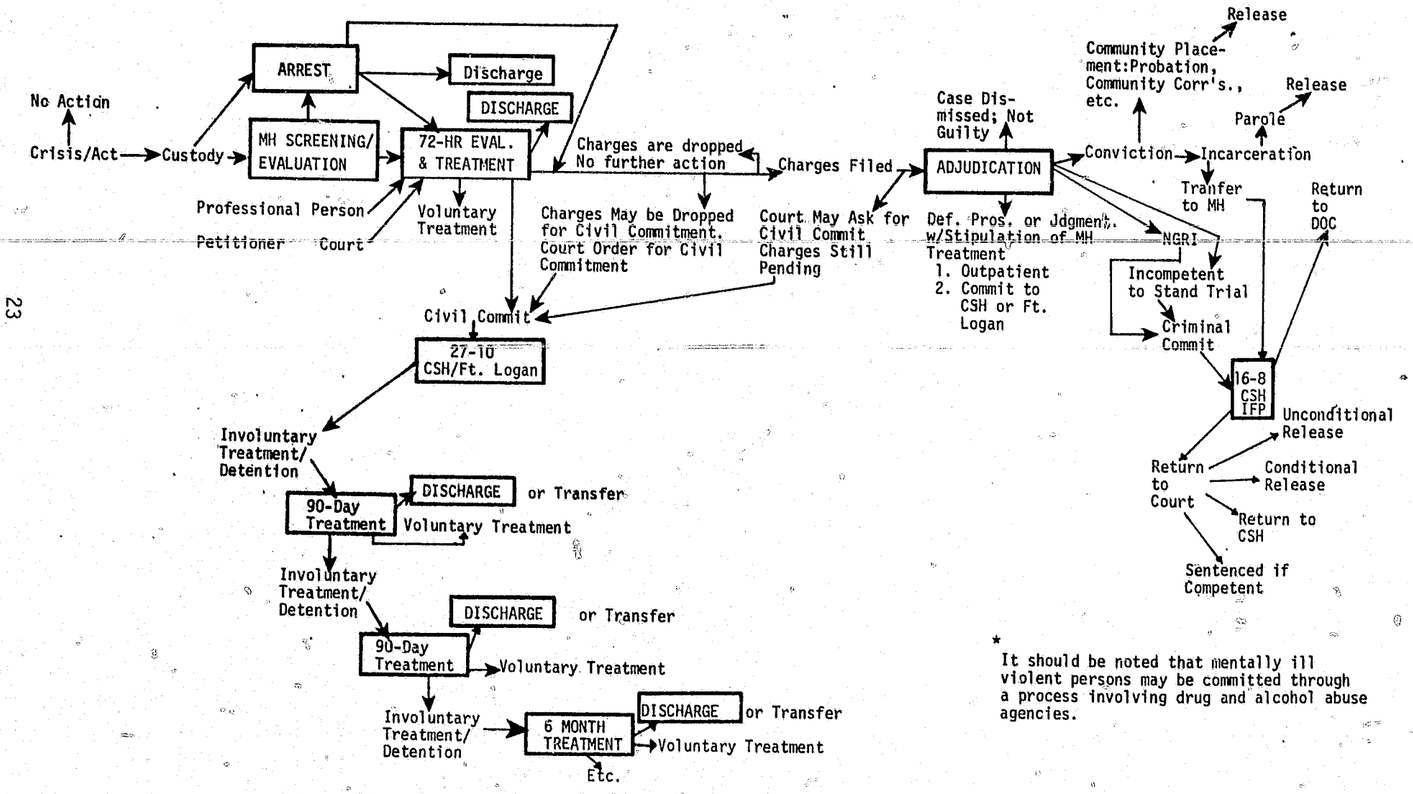
4. An incompetent-to-proceed defendant may not be confined for longer than the maximum term he could have served had he been convicted of the charged offense, less minimum good time credit.

5. The court must review the case at least every six months.

6. If the defendant will not be restored to competency within the foreseeable future, the court must terminate criminal proceedings and order release or commencement of proceedings under 27-10.

TABLE 1

COMMITMENT PROCESS*



* It should be noted that mentally ill violent persons may be committed through a process involving drug and alcohol abuse agencies.

CHAPTER II: PUBLIC SAFETY AND PATIENTS' RIGHTS: THE CARE AND TREATMENT OF THE MENTALLY ILL IN COLORADO

Several processes have converged to place Colorado's mental health system in a near crisis situation:

1. The increasingly stringent criteria for commitment and treatment of the mentally ill.

2. Overcrowding in the state hospitals.

3. Increasing costs with no comparable increase in funding.

The crisis has been further aggravated by media coverage of several incidents involving former mental patients. Public alarm kindled by the media has led to much criticism of the mental health and criminal justice systems' handling of the mentally ill, dangerous, or potentially dangerous person. There have been demands for stronger security measures and for longer confinements, for better surveillance of released patients, and for better ways of identifying mentally ill persons who are likely to be dangerous.

This study, including the problem identification and task force recommendations in this chapter, are in response to a request by the Department of Institutions for an analysis of the issues and the establishment of a statewide, multi-disciplinary task force to address the problems involving dangerous mentally ill persons. In this regard, the Department of Institutions requested the task force to address the following issues:

- The need for a more integrated data system.
- The need for uniform procedures and practices.
- Methods for establishing more mutual understanding of the three systems and a permanent mechanism for addressing common problems.
- The public policy of preventive detention and the issues which result from it.

This chapter presents information on these issues collected from several sources: a survey of criminal justice and mental health practitioners; agency information; Colorado research studies on mental health questions; task force activities; and violent offenders profile data. A discussion of methods is included in Appendix A.

The chapter is divided into four sections. First, an overview of broad issues which affect the system is presented; second, issues related to system entry are described and analyzed; third, treatment and placement issues; and last, release and followup issues.

SYSTEM ISSUES

Increased demand, shortage of resources, undesirable (untreatable) clients, poor communication, lack of needed information, no standard definitions,

procedures and criteria, fear of liability, "turf" issues - - these themes are found throughout the following narrative of mental health and criminal justice problems with DMIPs. These are the conditions under which agencies operate - - conditions which affect their performance capability. These problems are aggravated by other conflicts which arise from the nature of the respective organization.

Many respondents from virtually every type of agency described conflicts regarding the mandate, the values or the purposes of their own agency or of other agencies with which they work. Some are as fundamental as the conflict between the duty to protect the public and the need to respect the individual rights of a given patient. This particular difficulty arises most frequently between different kinds of agencies (e.g., law enforcement versus mental health treatment), but it exists within agencies as well. Similarly, mental health practitioners are sometimes ambivalent about their role as state officials, with responsibilities to the public which may not mesh well with their professional views toward the patient's right to accept treatment, the right to treatment in the least restrictive setting, and client confidentiality.

These problems are all interrelated. For example, the shortage of resources affects funding distribution which in turn decreases the probability that the community mental health center will identify, admit, treat, and followup an assaultive, resistive and costly client.

For analytical purposes, however, the problems can be summarized in two broad categories: lack of resources and organizational issues. Sections two, three and four of this chapter address more specific problems within these two categories as they relate to entry, placement and release.

VOLUME OF DMIPS

No one knows how many dangerous mentally ill persons are in Colorado's communities or in its mental health and criminal justice systems. Efforts to count them have proven futile (methods section, this report, and Miller, 1981). Neither mental health nor law enforcement agencies collect and agggregate information which would identify DMIPs. The information might possibly be manually retrieved, however, there still would be problems such as a standard definition for DMIP, the unreliability of mental health data on criminal variables, and law enforcement data on mental health variables.

Division of Mental Health data were analyzed for indicators of dangerousness to arrive at an estimate of the number of dangerous mentally ill, and survey respondents were asked if they felt there had been an increase since January 1979. We looked at the admissions for 1979-80 which included clinical assessments of (1) being dangerous to others, and (2) having committed offenses against persons. Of 50,542 admission episodes, 3.6 percent (1825) fell into this category. By type of agency, community mental health centers reported 2.5 percent (1196); Fort Logan 20.2 percent (175); and CSH 18.7 percent (454). Using this indicator to compute a rate of DMIP admission episodes (using 1980 census data), there were .63 admissions for every 1000 persons in Colorado (about one admission for every 1600 persons).

Several additional variables provide some indications of dangerousness. The figures in the following table are taken from the Division of Mental Health Evaluation Report #28 and from a tape of FY 1979/80 admission data.

This data was also compared to county size to determine whether or not differences exist in urban versus rural areas. Denver and El Paso counties were analyzed separately, Denver metro counties were grouped as were other large counties to include Larimer, Weld, Pueblo and Mesa. The balance of the state was grouped as rural. Although there were some differences between the groups in the various characteristics, there was not a clear pattern to indicate that these characteristics are more prevalent in either urban centers or rural areas.

TABLE 2

CLIENT CHARACTERISTICS FY 1979 - 1980

	MHCs		FLMHC		CSH	
Referred by Criminal Justice Agencies	4399	10%	67	9.0%	935	38.6%
Criminal Legal Status	1252	3	20	2.3	456	18.8
Primary Problem Area						
Forensic	1041	2	17	2.0	456	18.8
Alcohol Abuse	2776	6	2	.2	158	6.5
Drug Abuse	673	1			36	1.5
Danger to Others	3233	7.6	289	40.1	771	34.7
Property Offense	3389	8	213	29.6	489	22.0
Person Offense	3822	9	223	31.0	627	28.3
Chronic, Recurrent Illness	6526	15.3	132	18.3	387	17.4

The alcohol/drug abuse units of the hospitals shown do not report under the same system. For further information, contact Dr. Diesenhaus, Division of Alcohol and Drug Abuse.

Of the cases which were classified as dangerous to others by the mental health system, 57 percent were voluntary commitments, 31.9 percent were involuntary-civil, and only 11.2 percent were criminal commitments. A similar pattern holds true for those patients identified as having an offense against persons: 64.6 percent were voluntary commitments, 20.4 percent involuntary-civil, and 15 percent involuntary-criminal.

Survey respondents were asked if there had been a change in the number of mentally ill dangerous or potentially dangerous persons seen by their agency since January 1979. 67.6 percent felt there had been an increase, 32.4 percent felt there was no change. None of the respondents felt there had been a decrease. The results are shown in the following table by agency type.

TABLE 3

NUMBER OF DANGEROUS MENTALLY ILL

	Mental Health		Law Enforcement		Judiciary		Total	
Greatly Increased	4	9.3%	6	8.1%	2	6.5%	12	8.1%
Increased	28	65.1	43	58.1	17	54.8	88	59.5
No Change	11	25.6	25	33.8	12	38.7	48	32.4
	43		74		31		148	

RESOURCES AND ALLOCATIONS

Lack of resources is the problem cited most frequently and by the widest variety of survey respondents. As with other state and local agencies in Colorado, the mental health system has not kept pace with inflation. In addition, cuts in federal funding have not been fully supplemented by funding from other sources and it is likely that there will be additional federal cuts in the future.

The 1981-82 Supplement to the Mental Health Plan describes the effects of decreasing resources on the care provided by the state hospitals. Several of these affect the care and treatment of the dangerous mentally ill.

- Fort Logan Mental Health Center has maintained a waiting list for admission of clients prescreened by community mental health centers as needing inpatient care for the past two years.
- The psychiatric bed to population ratio of .3 per 1000 population in the Fort Logan service area is well below the National Institute of Mental Health standard of .5 to 1.0 beds per 1000 population.
- The two state hospitals are understaffed in clinical areas by a total of 74 FTE.
- Rates of injury to the staff at Colorado State Hospital due to patient contact has tripled in the past ten years.
- There are few effective treatment models for the violent mentally ill. The Forensic Unit at CSH and the Closed Adolescent Treatment Center in the Division of Youth Services are the only two models which exist in Colorado.

The community mental health centers have also been affected by rising inflation, cuts in federal funds and increasing patient caseloads. Mental health centers receive funding from state, federal and local government, fees, and donations. Approximately 40 percent of their funding is through purchase of service contracts with the Division of Mental Health. Every spring, DMH negotiates a contract with each mental health center which specifies expectations concerning the agency's provision of services during the coming fiscal year. The contract specifies a minimum number of admissions by age, severity and ethnic background. The minimum number of admissions are determined by analyzing the demographic composition of the catchment area population, estimates concerning the population in need, the agency's previous workload trends, the existence of other mental health resources in the community, and the agency's capacity for effecting change in the workload. Once the contract price is determined for the year it will not change as long as the minimum number of admissions is served.

The lack of resources available to the state hospitals and mental health centers and the nature of the purchase of service contracts have several implications for the care and treatment of the dangerous mentally ill.

Survey respondents were asked if the bed shortage at the two state treatment facilities affects decisions to commit. Two thirds of the respondents (66.4

percent) felt that the bed shortage did affect decisions to commit. Release decisions are also affected by the bed shortage. Additional discussion of the effects of bed shortages is provided in the sections which follow.

The lack of adequate resources and the purchase of service contracts for state funds also affect the community mental health centers' willingness and ability to accept referrals from criminal justice agencies and to treat the dangerous mentally ill. The lack of state hospital beds also affects the community mental health centers capability to provide a full range of services to their catchment area population.

Many of the dangerous mentally ill have a long history of criminal justice and mental health problems. They are often disruptive and resist or refuse treatment. They require a large expenditure of staff time and resources, often with limited results. The resources expended on these clients must be taken from programs for other clients who may be more receptive to treatment.

The bed shortage at the state hospitals also drains the resources of the mental health centers as they attempt to provide services to those patients who need to be hospitalized. A letter from Thelma Knight and James Humes of Arapahoe Mental Health Center, Inc. to the Editor of the Denver Post on March 6, 1981 describes the impact on that center's services and resources:

"Arapahoe Center's response to this has been to shift its resources in order to begin to provide private hospitalization when that has been deemed most appropriate for the patient and the community. The cost, however, has been staggering in two major respects.

1. The 'shift in resources' simply means eroding other program elements. For example, as staff vacancies have occurred in outpatient services, they have not been refilled in order to meet the costs of hospitalization of patients in private hospitals. To continue to pursue this strategy will result in increasingly longer waiting lists and at the extreme a lack of availability of services altogether.

2. Through December 31, 1980, the center has spent nearly $40,000 for hospital costs. It must be noted that the center receives no state funds for this, and that, as noted above, has done so solely by eliminating other, equally needed services.

AMHC is rapidly approaching the time when we simply cannot afford to continue to privately hospitalize patients. For us to endanger the provision of other services would be clinically irresponsible; to endanger the fiscal integrity of the entire center would be equally irresponsible."

SURVEY RESPONDENT RECOMMENDATIONS

- Additional beds should be provided.
- A portion of mental health funding should be targeted for dangerous mentally ill persons.

  48.8% agreed
  29.3% disagreed
  21.9% had no opinion

- A mental health facility should be provided on the western slope.
- The funding mechanism for certifying patients should be changed to eliminate the disincentive for certifying patients.

TASK FORCE RECOMMENDATIONS *

- THERE IS A CRITICAL NEED FOR A SUBSTANTIAL INCREASE IN BOTH THE NUMBER OF SECURE AND NON-FORENSIC PSYCHIATRIC BEDS IN ORDER TO PROVIDE THE CAPABILITY OF TREATING THE DANGEROUS MENTALLY ILL.
  - There should be more beds and a better staff/patient ratio at Colorado State Hospital, Ft. Logan, and the Denver area.
  - There should be more intermediate security beds at Colorado State Hospital.
  - There should be a greater number of secure beds in decentralized locations.

RESPONSIBILITY AND OWNERSHIP

Much of the conflict between the mental health and criminal justice systems in reference to the dangerous mentally ill revolves around issues of responsibility and ownership. The fact that the individual is dangerous implies that the criminal justice system should be responsible, and often initial contacts with the person are made by law enforcement. However, if the person is mentally ill, shouldn't the mental health system be responsible?

Conflicts arise between law enforcement and mental health at the point of entry into the system regarding appropriateness of referral, differing definitions of dangerousness and adequacy of care and treatment. The law provides two commitment processes, one civil, the other criminal. Most of the dangerous mentally ill could be committed under either process. The courts are involved in the commitment process, treatment decisions and release decisions. Many mental health practitioners feel that these decisions should be made by them with little or no court involvement. Conflicts also arise over the question of whether DMIPs should be held and treated in jails and prisons or in hospital settings. Associated with this issue is the issue of who should transport DMIPs, law enforcement or mental health. Who is responsible for followup and enforcement of conditions of release is also unclear. This issue is further complicated when the overlapping responsibilities of drug and alcohol and social services are considered. Many of the clients being discussed also require the services of these agencies.

*Task force discussions of recommendations are reported in the minutes, Appendix B.

Many of the responsibilities are not clearly defined in the statutes and/or procedures. Survey respondents were asked who they felt should have responsibility for the dangerous mentally ill. The results are shown in the following table.

TABLE 4

RESPONSIBILITY FOR DANGEROUS MENTALLY ILL

	Mental Health		Law Enforcement		Judiciary		Total	
Mental Health	19	40.4%	54	70.1%	24	61.5%	97	59.5%
Criminal Justice	10	21.3	10	13.0	3	7.7	23	14.1
Both CJ & MH	14	29.8	5	6.5	3	7.7	22	13.5
No Opinion	4	8.5	8	10.4	9	23.1	21	12.9
	47		77		39		163	

Criminal justice respondents were more likely to think that major responsibility for the dangerous mentally ill lies with the mental health system. Only 40.4 percent of the mental health professionals felt that this was their responsibility compared to about 65 percent of the criminal justice respondents. Mental health practitioners were more likely to see this as a criminal justice or a joint criminal justice/mental health responsibility.

Responsibilities of each of the systems appear to be more clearly defined in cases where there is either a serious offense of no offense but dangerous behavior. For less serious cases, dangerousness and mental illness seem to create the greatest number of problems in terms of system responsibility. In many cases the charges may be dropped and a civil commitment will be pursued.

The following table shows areas of overlapping responsibility for dangerous mentally ill persons.

TABLE 5

SYSTEM RESPONSIBILITY FOR THE MENTALLY ILL AND/OR THE CRIMINAL

	Mentally Ill: Dangerous as a Result of MI	Mentally Ill: Not Dangerous as a Result of MI	Not Mentally Ill
More Serious Offense	Criminal Justice Forensic	Criminal Justice Forensic	Criminal Justice
Less Serious Offense	Criminal Justice Forensic or Mental Health	Criminal Justice Forensic or Mental Health (Volun)	Criminal Justice
No Offense	Mental Health	Mental Health (Volun)	No Intervention

In many cases the primary responsibility for an individual is not clear because of mental health problems and minor offenses both associated with the same case. Many clients have had numerous contacts with both systems. The following case summary taken from a mental health center file helps to illustrate this point. The complete case history is included in Appendix

Patient X has a list of 27 contacts with law enforcement and mental health agencies dating back to 1970. The first contact with mental health occurred in 1973 as a result of an LSD overdose. The list of police contacts includes offenses such as trespassing, hitchhiking, disturbing the peace, criminal mischief, indecent exposure and arson, as well as numerous suicide attempts. Patient X has been jailed many times, and treated at Fort Logan, a nursing home, a residential treatment facility, and CSH.

Associated with the problem of responsibility between the two systems is the issue of ownership and catchment or service area. The state is divided into 20 catchment areas for mental health services. Each catchment has a community mental health center which is responsible for providing comprehensive community mental health services within that specified geographical area. Mental health centers receive funding from several sources which include federal, state and county governments, fees, etc. Many of their funds can be used only for the clients in their catchment area. This creates problems when an emergency arises with a person who is not a resident of the catchment area in which the incident occurs.

Survey respondents were asked if ownership is a serious problem in properly placing the dangerous mentally ill. Sixty-six percent felt that it is a serious problem, 16.6 percent disagreed and 17.3 percent had no opinion.

This is especially a problem in the Denver Metro area where there are numerous catchment areas but where people often cross catchment area boundaries. The following case of a law enforcement agency trying to place a person who they felt was in need of mental health services illustrates some of the problems associated with catchment areas and responsibilities between systems.

Police were called by the attorney of a 34 year old man. The man had gone to the attorney to discuss his problems and the attorney believed the man to be homicidal and suicidal. The police and the attorney tried to find a placement for this individual. They called the Mental Health Center #1, were referred to MHC #2 who referred them to MHC #3 because the man was not in their catchment area. Mental Health Center #3 was familiar with the case but would not accept the client because he had an outstanding bill. They referred him back to MHC #2 which referred him back to MHC #3. MHC #3 said he must pay his bill and that he has a drug problem, so referred him to Drug Center #1 who said they could not take him because he was not currently on drugs and referred him back to MHC #3. MHC #3 then called Fort Logan and asked them not to accept the client. The police then told the MHC #3 that they would ask the judge to order that the person be accepted. MHC #3 then referred the client to Drug Center #2 where he was placed. He was held for approximately one hour and was released. The following day he returned to his attorney's office. The police were again called and took the client to BPI for a 72 hour mental health hold. He was held for less than three hours and was released as no risk.

The state is also divided into service areas for use of the two state hospitals. Several respondents felt that these service areas were not equitable and that

placements are more difficult in the Fort Logan service area.

The two state hospitals, Fort Logan Mental Health Center (FLMHC) and Colorado State Hospital (CSH) received 3,291 new admissions in FY 1979-80, 868 in FLMHC and 2,423 in CSH. Fort Logan provides services for clients from the north and east third of the state including the Denver Metro area. CSH provides services to clients from the balance of the state. The map on the following page shows the two service areas and rates of commitment to the state hospitals. Commitment rates per 100,000 population tend to vary considerably by county, but the rates overall are higher in the CSH service area which may support the feeling that the service areas are not equitable. Rates tend to be higher in the rural areas than in urban centers. Pueblo has the highest rate per county, 499.3 per 100,000 compared to several small counties which had no commitments. Denver has a rate of 82.2 per 100,000 compared to three of the four large suburban counties where the rate is in the mid to high 30s range. El Paso county appears to have a relatively high rate, 190.0 per 100,000 when compared to other urban centers.

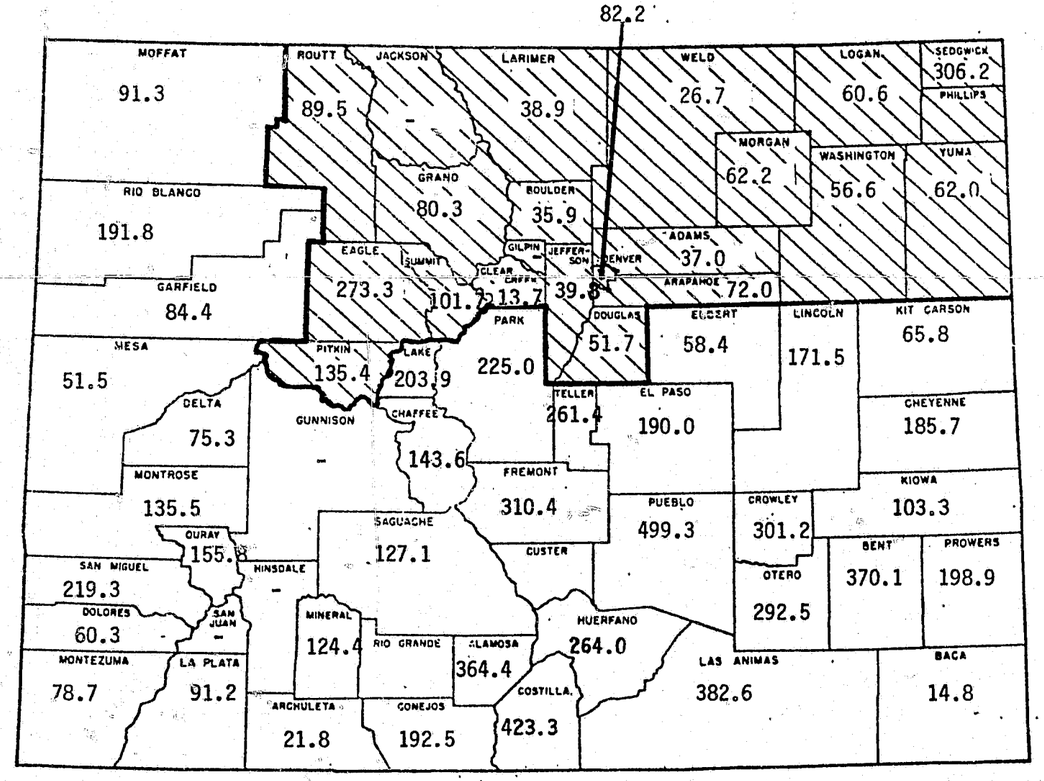
SURVEY RESPONDENT RECOMMENDATIONS

- Colorado State Hospital should allocate beds for DMIPs regardless of catchment area.
- Service areas for Fort Logan and Colorado State Hospital should be equalized.

TASK FORCE RECOMMENDATIONS

- THERE SHOULD BE IMPROVED STANDARDS FOR THE TREATMENT OF DANGEROUS MENTALLY ILL PATIENTS COMBINED WITH ACCREDITATION PROCEDURES FOR THE MENTAL HEALTH CENTERS. SITE VISITS SHOULD BE MADE BY SUPERVISING OFFICIALS TO INSURE COMPLIANCE WITH THESE STANDARDS.
- THE SERVICE AREAS FOR THE TWO HOSPITALS SHOULD BE ELIMINATED OR REDEFINED.
- THE STATE SHOULD ASSUME GREATER RESPONSIBILITY FOR DEVELOPING A CENTRALLY CONTROLLED AND ADMINISTERED SYSTEM WITH DECENTRALIZED DELIVERY FOR THE SPECIAL POPULATION OF DANGEROUS MENTALLY ILL PERSONS. THERE SHOULD BE A STUDY TO DETERMINE THE NEED FOR AN INTEGRATED STATEWIDE SYSTEM WITH RESPONSIBILITIES DEFINED FOR MENTAL HEALTH CARE DELIVERY. A CORE FORENSIC CAPABILITY SHOULD BE DEVELOPED TO CONSIST OF SPECIALISTS IN THE DIAGNOSIS, ASSESSMENT, STATEWIDE FOLLOWUP AND CONTINUITY OF CARE OF DANGEROUS MENTALLY ILL PERSONS. THE FORENSIC SPECIALISTS WOULD RECEIVE THE TRAINING AND BE GIVEN THE AUTHORITY APPROPRIATE TO THE TASKS. EACH FORENSIC UNIT WOULD BE RESPONSIBLE FOR THE FOLLOWING ACTIVITIES CONCERNING THE DANGEROUS MENTALLY ILL PERSON:
  - assessment;
  - diagnosis;
  - long term treatment plan;
  - statewide followup of dangerous mentally ill persons; and
  - coordination of actions and information within and between agencies.
- THE FUNDING MECHANISM FOR CERTIFYING PATIENTS SHOULD BE CHANGED TO ELIMINATE THE DISINCENTIVE FOR CERTIFYING AND/OR HOSPITALIZING PATIENTS.

STATE HOSPITALS' SERVICE AREA



Colorado State Hospital Service Area Fort Logan Mental Health Center Service Area

UNIFORM POLICIES AND PROCEDURES

Many agencies which deal with the dangerous mentally ill do not have written policies and procedures for their care and treatment. In other cases, uniform procedures have been established but are not adhered to. The lack of uniform procedures and practices can lead to disparate treatment of the clients, conflicts between agencies and a risk to the client, staff or others.

As a part of the survey, respondents were asked for copies of written procedures

for handling the dangerous mentally ill. Many agencies had no written procedures which could be provided. Mental health centers, law enforcement agencies and emergency rooms, those agencies thought to have the most contact with the dangerous mentally ill under crisis circumstances, were asked if they had established procedures for handling these crises. Only 40.5 percent indicated their agency did. Only 19 percent had established procedures for identifying dangerous behavior or situations.

Several practices were identified through the survey where a lack of written policies and procedures can result in the inconsistent handling and treatment of the dangerous mentally ill. The inconsistencies may be within an agency from one case to another or by similar agencies in different jurisdictions. The following are examples of practices resulting in inconsistencies.

- Civil vs Criminal Commitment

  In some areas of the state the district attorney will pursue a criminal commitment if a crime was committed and will not drop charges in order to civilly commit. In other cases the district attorney will assess the seriousness of the crime and the level of mental illness and decide not to prosecute in exchange for a civil commitment.

  CRS 27-10-123 provides that proceedings related to 72 hour holds for evaluation and certification for short term treatment "shall not be initiated or carried out involving a person charged with a criminal offense unless or until the criminal offense has been tried or dismissed; except that the judge of the court wherein the criminal charge is pending may request the district or probate court to authorize and permit such proceedings." This section of the statute is being interpreted differently by various agencies and in various parts of the state. In many cases, it is being interpreted by both mental health and criminal justice practitioners to mean that all pending criminal charges must be dropped before mental health services can be provided. As a result, law enforcement and the district attorney may drop the charges against a person so that they can receive mental health services. Conflict arises when the mental health center then releases the person without providing services.

- Not guilty by reason of insanity pleas

  Public defenders do not have uniform practices for representing dangerous mentally ill clients. For example, in one area of the state public defenders enter mental health pleas for most cases involving violence. Another public defender avoids mental health pleas because of the feeling that mental health facilities are worse than correctional facilities.

Several respondents indicated that their agency has contact with only a few cases where the person is dangerous and mentally ill. However, when such a situation does occur it becomes a crisis which may result in an inappropriate response to the situation. For example, if law enforcement is called to the scene of an incident, it is important to be able to recognize if the individual has mental problems in addition to responding to a criminal offense.

Also, the lack of procedures may result in additional agency staff resources to determine how to handle a case. This was expressed by respondents at several levels. For example, one judge indicated that he hears very few of these cases but every time one comes up he and the district attorney spend numerous hours researching the statutes to determine how to handle the case.

TRAINING

Respondents expressed a need for training in all phases of the identification and treatment of dangerous mentally ill persons; in particular:

1. identification

2. understanding and knowledge of interagency functions and responsibilities

3. treatment.

Both law enforcement and mental health practitioners perceived a need for training in identifying persons who are dangerous as a result of mental illness. Mental health professionals lack training on how to handle violent clients and law enforcement on how to handle problems resulting from mental illness.

There is also a great need for cross training in the criminal justice and mental health systems. Many problems arise from the lack of knowledge or understanding of other agencies' roles, values, responsibilities, legal mandates and limitations. The people surveyed felt there is a real need for this type of training. 98.7 percent of the respondents agreed with the statement that staff training programs should include a component on the functions and problems of other agencies involved in handling the dangerous mentally ill person.

Responses to open ended questions give further evidence of the need for training. Many responses indicated a lack of knowledge or understanding of the statutes, case law, and regulations which govern treatment of the mentally ill. There is also much misinformation about what other agencies actually do, misinformation which aggravates relationships which already may be strained by trying to serve too many clients with too few resources.

The smaller law enforcement agencies which infrequently handle dangerous mentally ill persons requested regularly scheduled training on statutes and regulations. Several respondents felt that a procedures manual which is periodically updated would be useful.

There are very few training programs nationwide that deal with the treatment, administrative and management issues regarding dangerous mentally ill persons. Suthenland-Miller's study reports on training programs in Colorado. He asked mental health centers about staff training programs and reports that "Nine out of the 14 centers who responded to this question provide no specialized training programs for staff to deal with the violent mentally ill client" (1980:53). Currently in Colorado, most officers receive only two hours of this type of training at CLETA. In a survey completed in Jefferson County, police mentioned the need for additional training in basic assessment, role play crisis training and a session on "how to communicate with mental health or describing the incident in terms of behavioral characteristics." They also felt that if mental health workers are to provide on-the-scene crisis intervention services, they need training in safety maintenance.

Miller reports an active educational program at CSH which supplements basic training in the following areas: (1) basic security measures and physical care aspects of working with the violent or aggressive patient; (2) recognition and treatment of individuals prone to self-destructive behavior;

(3) recognition, evaluation, treatment and release planning for individuals prone to violent or aggressive behavior toward others (p. 57). The training at Fort Logan, however, is very inadequate, Miller says, because of staff shortages which preclude staff training time.

Training is also needed for jailers in how to manage mentally ill offenders. In the absence of training, only custodial care is given the mentally ill in jail.

There was also a feeling among several survey respondents that additional training is needed for those involved in the court process to include the judges, district attorneys, and public defenders. This should include training on the statutes and the process.

TASK FORCE RECOMMENDATIONS

- MORE EDUCATION/TRAINING SHOULD BE PROVIDED TO MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES AND THE LEGAL SYSTEM REGARDING WHAT CAN AND WHAT CANNOT BE DONE UNDER THE CURRENT STATUTES. THERE SHOULD BE CROSS TRAINING BETWEEN MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES.

- MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD PROVIDE INSTRUCTION (CROSS TRAINING) TO JAILERS ON TREATMENT.

INFORMATION EXCHANGE

Survey respondents reported that serious problems occur when patient records are incomplete or unavailable. There are no standard procedures for the transfer of information on criminal history, medication and treatment, but such information is vital for the correct assessment, placement, treatment and followup of dangerous mentally ill persons. For example, the state hospital received a patient charged with second degree burglary, and having no additional information placed the patient in the surgical ward. They later discovered, after the patient escaped, that he had been previously convicted of murder.

Further, mental health centers and law enforcement agencies do not routinely receive files on dangerous patients placed in their area. If the patient later decompensates, neither law enforcement nor mental health practitioners have information on the patient's problems and treatment plan. This can be particularly serious in that the type of medication which is effective is often particular to the patient.

Police referrals to mental health is another area where needed information is not always transferred. In developing policies, mental health centers usually have not considered law enforcement's need to know disposition of referred offenders. One center's policy on information exchange states that:

> "When a client is referred by another professional or agency it is acceptable to inform the referring party that contact has been made with the client. It is not acceptable to release any other information without a signed release."

They also may not value the police officer's account of the incident - an important source of information concerning the offense.

The gaps in information are in part due to problems discussed elsewhere in this report, such as shortage of personnel, standard procedures, conflict in mandate and purpose, and fear of liability. The complexity of the statutes also adds to the problem. Information exchange is covered by both the mental health statute and the criminal justice records sections of the public records statute.

The mental health statute specifies the conditions under which patient information can be exchanged. The following provisions are very restrictive, but many practitioners interpret them even more narrowly than may be required; for example, by not replying to a request for information if there is some doubt that the recipient is a qualified professional person as specified in (a) below.

> 27-10-120 Records. (1) All information obtained and records prepared in the course of providing any services under this article to individuals under any provision of this article shall be confidential and privileged matter. Such information and records may be disclosed only:
> (a) In communications between qualified professional persons in the provision of services of appropriate referrals;
> (b) When the recipient of services designates persons to whom information or records may be released; but, if a recipient of services is a ward or conservatee and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the recipient; except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him in confidence by members of a patient's family;
> (c) To the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which he may be entitled;
> (d) For research, if the department has promulgated rules for the conduct of research. Such rules shall include, but not be limited to, the requirement that all researchers must sign an oath of confidentiality.
> (e) To the courts, as necessary to the administration of justice;
> (f) To persons authorized by an order of court after notice and opportunity for hearing to the person whom the record or information pertains and the custodian of the record or information pursuant to the Colorado rules of civil procedure.

The statute makes no provision for the disclosure of information specifically to police officers. The question is whether they would be considered qualified professional persons making referrals.

As noted earlier, needed information on criminal records is sometimes incomplete or unavailable. The statute governing release of criminal justice records (CRS (1973) 24-72-301 to 309 as amended) is long and complex. A brief review of its provisions shows why some agencies may find it difficult to respond to requests for information. Although criminal justice records are public, the provisions for sealing and limiting access to criminal records allows the subject of a criminal charge or conviction to ask that records be closed in certain situations:

1. Five years after completion of a sentence for a misdemeanor (or less) conviction if there are no intervening formal charges for another crime, other than a petty offense or class 3 or 4 misdemeanor traffic offense.

2. Seven years after a felony under the same circumstances.

The court, as a matter of course, limits access to arrest and criminal records when the record is of an official action in which the individual is acquitted or the charges are dismissed. The order for limited access is entered 30 days after the dismissal or acquittal. Part (1.2)(b) of this section specifies that such records will be sealed to everyone except the subject, a criminal justice of this state, or a similar agency of the United States government or any of the states of the United States of America.

Once the order to seal the records has been entered, the subject or the district attorney must petition the court for permission to inspect the records. Part 4 provides that:

> "the subject official actions shall be deemed never to have occurred, and the person in interest and all criminal justice agencies may properly reply, upon any inquiry in the matter, that no such action ever occurred and that no such record exists with respect to such person."

When records are sealed, all the agencies involved are notified, including the Colorado Bureau of Investigation. The sealing and limiting access of records provided for in this statute applies to deferred prosecutions and deferred judgments and sentences where the stipulations of the sentence have been satisfied and the charges dismissed. Since this is a mechanism used by the court to effect hospitalization of mentally ill offenders, it may be a barrier to exchange of information on dangerous mentally ill persons. The information is available for the period of deferment, but if an offense is committed or dangerousness as a result of mental illness reoccurs subsequent to completion of the deferment, a petition must be filed for access to the information.

Another barrier to information exchange is the separation between the civil/criminal commitment process. Where criminal charges are dropped for a civil commitment, or where a previously convicted person is civilly committed, criminal history variables are not available to the court for commitment decisions unless they happen to be recorded in the patient's medical file.

To alleviate the problems discussed above, 87.5 percent of the survey respondents felt that a legal or administrative mechanism should be developed for sharing information about dangerous mentally ill persons with other involved agencies. **Only 7.5 percent disagree.** The only agency type which opposed information exchange was the public defender. 55.6 percent of those interviewed opposed such a mechanism.

SURVEY RESPONDENT RECOMMENDATIONS

- Mental health should have a better system of coordination and information exchange.

- Statutes should be changed to allow for case information to be exchanged under certain circumstances.

- Involved agencies and potential victims should be notified and this notification verified before potentially dangerous mentally ill persons are released from CSH or Fort Logan.

- The Colorado State Hospital should try to get out more information on conditionally released people.

- The mental health centers should be impressed with the fact that probation needs more ongoing information.

- The Judiciary should be provided feedback on behavior and progress of patients placed by court order.

TASK FORCE RECOMMENDATIONS

- COMMUNICATION BETWEEN AND WITHIN THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS SHOULD BE IMPROVED.

  - LOCAL JURISDICTIONS SHOULD SET UP A MECHANISM FOR EXCHANGING INFORMATION, TO INCLUDE COMMON WRITTEN GUIDELINES. MENTAL HEALTH CENTERS SHOULD TAKE THE LEAD. EXTERNAL HELP IN SETTING UP THESE MEETINGS SHOULD BE PROVIDED BY TASK FORCE MEMBERS, THE DIVISION OF MENTAL HEALTH OR THE DIVISION OF CRIMINAL JUSTICE STAFF, OR OTHERS TO PROVIDE PERTINENT MATERIALS REGARDING PROBLEMS OR ISSUES TO BE ADDRESSED.

  - A FULL POLICE REPORT REGARDING THE INCIDENT AND CRIMIN AL HISTORY SHOULD BE TRANSFERRED WITH PERSONS REFERRED TO MENTAL HEALTH CENTERS BY THE POLICE.

  - BETTER USE SHOULD BE MADE OF THE PRESENT STATUTES REGARDING EXCHANGE OF INFORMATION BETWEEN TREATMENT AGENCIES.

  - REVIEW AND CHANGE, IF NECESSARY, THE STATUTES WHICH LIMIT THE EXCHANGE OF INFORMATION NEEDED FOR THE PROPER CARE, TREATMENT, AND FOLLOWUP OF THE DANGEROUS MENTALLY ILL.

  - THE STATE HOSPITALS SHOULD HAVE ACCESS TO CCIC TERMINALS IN ORDER TO CHECK CRIMINAL HISTORY RECORDS OF INCOMING PATIENTS.

  - A MENTAL HEALTH "RAP SHEET" TYPE REPORT SHOULD BE PREPARED BY THE MENTAL HEALTH CENTERS AND MADE AVAILABLE TO OTHER MENTAL HEALTH OR CRIMINAL JUSTICE AGENCIES WHICH MUST PROVIDE SERVICES TO A DANGEROUS MENTALLY ILL PERSON. (THIS RECOMMENDATION MAY REQUIRE A LEGAL OPINION OR A STATUTE CHANGE.)

LIABILITY

The litigation which has resulted in a new body of mental health law emphasizing patients' rights has also created an aura of fear around decisions involving the care, treatment and release of, and exchange of information concerning, the mentally ill. The literature review and the review of Colorado case law touched on this issue.

Although liability suits have not been frequent in Colorado, their great potential for destruction of professional reputations and agency capability to provide services to the mentally ill requires that the legal ramifications of every decision be considered. In Colorado, suits have been filed charging professionals and a mental health center with negligence. In the DelaCruz case, a mental health center and two physicians were charged with negligently permitting David DelaCruz to remain at large even though they knew he was dangerous. Damages of $11 million were asked.

Two other cases have recently been filed on behalf of patients who have been denied care by the Colorado Mental Health System. Thus, decision makers are confronted with the dilemma of protecting the public without violating the individual's rights as a mental patient such as treatment in the least restrictive setting, informed consent, the right to refuse treatment, and confidentiality. It is interesting to note that the suits filed, contrary to fears expressed by respondents, are on behalf of patients who have been denied care or placed in an insufficiently restrictive setting.

Law enforcement officers are also concerned with the liability issue. In cases where no offense has been committed, the statutes limit their involvement to emergency situations involving the dangerously mentally ill. There are laws or regulations governing treatment and transportation of the mentally ill, which if not followed might result in a liability suit.

Jailers, too, have specific regulations covering the care and treatment of the mentally ill. The conditions of some facilities preclude following these regulations, so jailers might be faced with the difficult choice of illegally detaining mentally ill persons or setting them free without treatment.

ENTRY INTO THE SYSTEM

As previously described, dangerous mentally ill persons may be committed to the mental health system in three ways:

1. criminal commitment
2. civil commitment
3. transfer from corrections

Before the commitment stage can be reached, however, practitioners from several systems must work together to identify and evaluate the potential patient. Although agencies tend to behave as if they are independent entities, their actions impact other parts of the system as one agency's solution becomes another's problem.

Problems related to system entry will be disucssed in the following order:

1. No uniform definition or criteria
   a. criteria for assessing dangerousness
   b. criteria for mental health referrals
   c. perceived accuracy of assessments

2. Criteria for determining whether to arrest or hold for mental health

3. Referrals to mental health - - evaluates, placement or release

4. The mentally ill in jail

DEFINITION OR CRITERIA FOR IDENTIFYING OR PREDICTING DANGEROUSNESS AND MENTAL ILLNESS

The lack of an operational definition of the dangerous mentally ill person is a source of friction between law enforcement and mental health practitioners (see literature review on definitions of dangerousness). In order to describe how respondents define and predict dangerousness, they were asked to rate a set of possible predictors on a scale from one to five, with one meaning the indicator was among the best predictors and five, among the least effective predictors of dangerousness to others. Results are presented in Table

Frequency of offenses was rated the most effective predictor of dangerousness to others. This was followed by recency and the seriousness of offenses, respectively. The relative ranks of the other predictors are presented in the table. Overall, respondents rated offense related factors as the best predictors of dangerousness and the social characteristics as the least effective. Clinician's judgment is rated about average, below offense related items and alcohol/drug abuse, but above social characteristics. Thus, our respondents concur with research findings which indicate that offense related variables are the most reliable predictors of future dangerousness: violent behavior predicts violent behavior.

That these are considered important variables is further supported by Miller, who reported that "Mental health centers generally use several of the following criteria to assess a clients's potential for violence:

1. History of violent acts or attempts (several centers indicated history is the best predictor of violent behavior).

2. Observation of violence.

3. Threats or plans of violence.

4. Delusions/hallucinations related to violence.

5. Poor impulse control.

6. Substance abuse patterns.

7. Access to weapons and other dangerous objects

8. Clinician's reactions and judgments." (1980:52-53)

Mary Koppin, Department of Research and Program Analysis at CSH has also conducted research which supports the proposition that offense related variables are most reliable in predicting future violence. Koppin, in a 1977 paper, validated the legal dangerousness scale derived by Cocozza and Steadman (1974),

in a retrospective study of dangerous behavior among criminally insane offenders in Colorado.

To determine whether mental health and criminal justice personnel differed on their ratings of these predictors, respondents were divided into these two groups and matched to the ratings. The results indicate that mental health respondents rate the mentally ill person's recency of violent acts, stress in precipitating situation, age and sex higher than criminal justice respondents. Criminal justice respondents rate the clinician's judgment higher in predictive value than mental health respondents. The latter finding suggests that criminal justice practitioners place more faith in mental health assessments than people in the mental health system. Both groups essentially agree on the ratings of the other predictors.

To further explore how agencies are identifying persons who are dangerous as a result of mental illness, respondents were asked to rate a set of mental health indicators to determine what factors best indicate future violence to others. Table presents the results of this analysis. Violent ideation is thought to be the best indicator of possible violence to others. The expression of paranoid ideas is also thought to be an important indicator. Intense motor activity was rated the lowest of the six factors.

Respondents who selected hallucinations as an important indicator specified that it is the content of the hallucinations which indicates dangerousness. Hallucinations such as those reported by New York's "Son of Sam," where an irresistible authority orders that someone be murdered, are good indicators of dangerousness. On the other hand, benign hallucinations would suggest the patient is not dangerous.

We also compared criminal justice with mental health choices for best indicator of mental illness which leads to violence. Mental health respondents rated verbal threats and violent ideas higher than criminal justice respondents, but criminal justice respondents rated bizarre behavior and hallucinations higher than mental health practitioners. Paranoid ideas and intense motor activity were rated about the same by both mental health and criminal justice respondents.

The suggestion is that the different experiences of criminal justice and mental health staff may create some of the disagreements about inappropriate referrals and inappropriate release. Law enforcement personnel routinely see people who make verbal threats and have violent ideas, and mental health workers routinely see those who exhibit bizarre behavior or hallucinate. Also, these concepts may have different meanings for law enforcement and mental health workers.

Another factor which can result in conflict between the two systems is the perception of many clinicians that the sociopath, i.e. one who manipulates the system for his own needs, uses valuable resources which could be more fruitfully spent elsewhere, is resistive to treatment and at times dangerous. Not all mental health professionals agree that sociopathy is a mental illness and many respondents felt that this group should be handled by the criminal justice system. The following quote from a Fort Logan employee, included in the Miller study, helps to illustrate this feeling:

> "The other side of the court coin is the failure to prosecute a sociopath because he can manipulate people into thinking "poor

little crazy kid." The upshot is that he is sent here as a deferred prosecution case, but the judge wants it to work like a sentence because he thinks that he really is guilty."

Most of the respondents believed the indicators of dangerousness used by their agency were accurate or very accurate (79.5 percent). Very few (8.9 percent) thought their indicators were inaccurate. The results suggest that, as far as each agency is concerned, practitioners have confidence in their assessments. Responses to other questions indicate they do not have the same confidence in assessments by other agencies.

These differences in definition or predictors of dangerousness and the respondents belief that the indicators of dangerousness are very accurate lead to some of the feeling among law enforcement officers that mental health professionals do not recognize dangerousness and that dangerous persons are not held long enough. Mental health professionals, on the other hand, often question the appropriateness of criminal justice referrals to the mental health system. These issues will be described in more detail on the following pages.

TASK FORCE RECOMMENDATIONS

- A STUDY SHOULD BE COMPLETED TO DEFINE THE DANGEROUS CLIENT AND TO DESCRIBE THE FOLLOWING ASPECTS OF THE DANGEROUS MENTALLY ILL POPULATION:
  - natural history
  - demography
  - frequency
  - recognition/prediction

REFERRALS TO MENTAL HEALTH SYSTEM

Many of the dangerous mentally ill enter the mental health system through an initial contact with law enforcement. In many cases the police are called to intervene in a crisis situation which is a threat to the offender or others. Many of these calls are made by family or friends of the offender and, as illustrated in the cases described in Appendix C, include such situations as suicide attempts, carrying and threatening self or others with a weapon, starting fires and assaults. Other calls first appear to be routinely criminal, involving offenses such as burglary or theft, with the offender's mental health problems showing up after arrest. If symptoms of mental illness are apparent immediately, the police officer may detain the person on a 72 hour mental health hold. Whether to take this action or arrest is one of the first decisions the police officer makes. Some police departments have established criteria for making such a determination. Following is an excerpt from a police procedures manual:

Criteria for Making the Determination

The criteria to be considered in determining whether mental health treatment is more appropriate than an arrest include:

TABLE 6

PREDICTORS OF DANGEROUSNESS TO OTHERS

BY CRIMINAL JUSTICE AND MENTAL HEALTH RESPONDENTS

Predictor	Rating: Best 1	2	3	4	Worst 5	Total
Recent Violence						
Mental Health	28 (62.2)	11 (24.5)	3 (6.7)	2 (4.4)	1 (2.2)	45 (100)
Crim Just	59 (55.1)	19 (17.8)	23 (21.5)	4 (3.7)	2 (1.9)	107 (100)
Frequent Vlnce						
Mental Health	38 (84.5)	5 (11.1)	1 (2.2)	0	1 (2.2)	45 (100)
Crim Just	78 (72.9)	19 (17.8)	4 (3.7)	4 (3.7)	2 (1.9)	107 (100)
Serious Vlnce						
Mental Health	34 (75.6)	6 (13.3)	4 (8.9)	1 (2.2)	0	45 (100)
Crim Just	57 (52.8)	30 (27.8)	12 (11.1)	7 (6.5)	2 (1.8)	108 (100)
Stress						
Mental Health	17 (40.5)	14 (33.3)	8 (19.1)	3 (7.1)	0	42 (100)
Crim Just	17 (16.7)	36 (35.3)	32 (31.4)	14 (13.7)	3 (2.9)	102 (100)
Age						
Mental Health	3 (7.1)	10 (23.8)	11 (26.2)	11 (26.2)	7 (16.7)	42 (100)
Crim Just	4 (4.4)	6 (6.6)	25 (27.5)	9 (9.9)	47 (51.6)	91 (100)
Sex						
Mental Health	5 (11.9)	12 (28.6)	12 (28.6)	5 (11.9)	8 (19.0)	42 (100)
Crim Just	4 (4.4)	7 (7.7)	17 (18.7)	13 (14.3)	50 (54.9)	91 (100)
Race						
Mental Health	1 (2.6)	2 (5.3)	11 (28.9)	7 (18.4)	17 (44.7)	38 (100)
Crim Just	3 (3.3)	1 (1.1)	12 (13.3)	19 (21.1)	55 (61.2)	90 (100)
Employment Stab						
Mental Health	2 (4.8)	7 (16.7)	19 (45.2)	11 (26.2)	3 (7.1)	42 (100)
Crim Just	6 (6.1)	19 (19.4)	32 (32.7)	24 (24.5)	17 (17.3)	98 (100)
Socio-Economic						
Mental Health	2 (4.8)	3 (7.1)	16 (38.1)	15 (35.7)	6 (14.3)	42 (100)
Crim Just	4 (4.1)	14 (14.4)	25 (25.8)	25 (25.8)	29 (29.9)	97 (100)
Substance Abuse						
Mental Health	23 (51.1)	15 (33.4)	6 (13.3)	1 (2.2)	0	45 (100)
Crim Just	32 (30.2)	51 (48.1)	16 (15.1)	5 (4.7)	2 (1.9)	106 (100)
Clinician Jdgmt						
Mental Health	9 (22.0)	13 (31.7)	14 (34.1)	5 (12.2)	0	41 (100)
Crim Just	29 (32.2)	35 (38.9)	20 (22.2)	5 (5.0)	1 (1.1)	90 (100)

TABLE 7

INDICATORS OF MENTAL ILLNESS THAT MAY RESULT IN VIOLENCE TO OTHERS
BY CRIMINAL JUSTICE AND MENTAL HEALTH RESPONDENTS

Indicator	Rating					Total
	Best 1	2	3	4	Worst 5	
Bizarre Behavior						
Mental Health	3 (7.1)	3 (7.1)	18 (43.0)	9 (21.4)	9 (21.4)	42 (100)
Criminal Justice	35 (34.0)	24 (23.3)	29 (28.1)	10 (9.2)	5 (4.9)	103 (100)
Verbal Threats						
Mental Health	8 (18.6)	18 (41.9)	12 (27.9)	4 (9.3)	1 (2.3)	43 (100)
Criminal Justice	19 (18.6)	30 (29.4)	28 (27.5)	19 (18.6)	6 (5.9)	102 (100)
Paranoid Ideas						
Mental Health	19 (42.2)	15 (33.3)	7 (15.6)	3 (6.7)	1 (2.2)	45 (100)
Criminal Justice	36 (34.0)	37 (35.0)	29 (27.9)	3 (2.8)	1 (0.9)	106 (100)
Violent Ideas						
Mental Health	28 (62.2)	14 (31.1)	2 (4.5)	1 (2.2)	0	45 (100)
Criminal Justice	42 (40.4)	36 (34.6)	19 (18.3)	4 (3.8)	3 (2.9)	104 (100)
Intense Motor Activity (Hyper)						
Mental Health	5 (12.2)	13 (31.7)	12 (29.3)	9 (21.9)	2 (4.9)	41 (100)
Criminal Justice	16 (16.0)	28 (28.0)	35 (34.0)	16 (16.0)	6 (6.0)	101 (100)
Hallucinations						
Mental Health	7 (16.3)	13 (30.2)	12 (27.9)	8 (18.6)	3 (7.0)	43 (100)
Criminal Justice	29 (29.0)	34 (33.0)	23 (23.0)	11 (11.0)	4 (4.0)	101 (100)

( ) = Percent

TABLE 8

FACTORS DETERMINING WHETHER LAW ENFORCEMENT AGENCIES ARREST OR DETAIN ON 72 HOUR HOLD DANGEROUS OFFENDERS

Factors	Rating (Most Important 1 / 2 / 3 / 4 / Least Important 5)					$\bar{x}$	Rank
Seriousness of Offense	30 (63.8)	11 (23.4)	5 (10.6)	0	1 (2.1)	1.532	1
Individual's Need for Treatment or Evaluation	20 (42.6)	23 (48.9)	3 (6.4)	0	1 (2.1)	1.702	2
Signs of Mental Illness	21 (44.7)	12 (25.5)	10 (21.3)	2 (4.3)	2 (4.3)	1.979	3
Previous Experience With Individual	12 (26.7)	17 (37.8)	9 (20.0)	4 (8.9)	3 (6.7)	2.311	4
Precipitating Situation	9 (20.0)	13 (28.9)	18 (40.0)	3 (6.7)	2 (4.4)	2.467	5
Expectation That Mental Health Will Evaluate and Release	6 (14.6)	8 (19.5)	11 (26.8)	6 (14.6)	10 (24.4)	3.146	6
Potential Behavior Problem in Jail	8 (21.1)	6 (15.8)	6 (15.8)	4 (10.5)	14 (36.8)	3.263	7
Overcrowding in Jail	7 (16.3)	6 (14.0)	8 (18.6)	6 (14.0)	16 (37.2)	3.419	8
Lack of Bed Space	8 (20.0)	1 (2.5)	3 (7.5)	7 (17.5)	21 (52.5)	3.800	9

\# = Frequency
( ) = Percent

1. The seriousness of the offense as balanced against the severity of the subject's apparent mental illness;

2. The subject's willingness to accept mental health treatment as balanced against the subject's competency to make a decision about accepting mental health treatment;

3. Any other factor which bears upon the individual officer's assessment of the balance of hardships to the individual and to society by diverting the subject from the criminal to the mental health system.

Survey results indicate that these criteria are generally used whether or not they are included in the procedures manual. As shown in Table 8 , seriousness of the offense is the most important factor in making the decision. This is followed by the individual's need for treatment or evaluation, previous experience with the individual, and the precipitating situation. Overcrowding in jails and the lack of bed space were rated very low.

This is important information for it implies that police arrest the more serious offenders who would then be admitted to the mental health system through the criminal insanity statutes or through a transfer from prison, while they opt for a mental health hold for the less serious offenders who would then be served through the civil system.

Several interagency conflicts were identified related to the process whereby a law enforcement officer suspects that an individual is mentally ill and refers the person to the community mental health center. These stem from the lack of uniformly accepted criteria for referral and to a lack of resources. The problems identified by the police include:

- MHC's untimely or inappropriate response to emergency calls
- Inadequate evaluations (evaluate and release)
- Failure to recognize dangerousness
- No feedback on referred clients

Problems identified by mental health practitioenrs include:

- Police department's failure to understand limitations imposed by mental health law
- Mental health centers are not paid to perform evaluations for police
- Police officers' inappropriate referrals for mental health evaluations

The following discussion presents the problems from both the police and mental health perspective.

Response Time

Since crises often occur in the evening and on weekends, and mental health centers usually operate with full staff from 8 or 9 AM to 5 PM, it is not

surprising that many respondents disagree with the statement that mental health professionals respond immediately to requests for emergency evaluations.

TABLE 9

MENTAL HEALTH PROFESSIONALS RESPOND IMMEDIATELY TO REQUESTS FOR EMERGENCY EVALUATIONS

	Strongly Agree		Agree		No Opinion		Disagree		Strongly Disagree	
Mental Health	12	31.6%	18	47.0%	1	3.0%	7	18.4%	0	0
Law Enforcement	18	15.7	46	40.4	12	10.5	28	24.6	10	8.8
Other	1	20.0	2	40.0	0	0	2	40.0	0	0
Total	31	19.7	66	42.0	13	8.3	37	23.6	10	6.4

It should be noted that slow response time is not a problem in all catchment areas. Over 56 percent of the law enforcement respondents reported that mental health professionals do respond immediately. Law enforcement respondents in Colorado West catchment area praised the work of the mental health professionals there, and felt their system could be used as a model for the state.

In fact, mental health policies may function to consistently lower the priorities assigned to calls from law enforcement. When mental health centers are contacted by law enforcement agencies the situation is usually under control, the weapon has been taken away and/or the person is in an emergency room or in jail. What is considered a crisis situation by law enforcement is considered a controlled situation by mental health. The following excerpt from a mental health center's procedures manual helps to illustrate this point.

> "Incoming calls, in the event of a back log, will be prioritized in the following manner:
>
> 1. Persons calling from unstructured settings, (e.g. home, a phone booth) shall receive first priority due to the potential dangerousness for the caller of these unsupervised situations.
>
> 2. Second priority shall be given to persons calling from alternative to hospitalization placements (e.g. I.T. House, Washington House, Community House, Nursing Homes). This is because of the limited availability and expertise of staff during off hours.
>
> 3. Third priority is given to persons involved with law enforcement officers. Though police do not have any formal expertise with mental health clients, they are capable of providing a high level of protection for the client and the community.
>
> 4. Fourth priority is given to persons calling from hospitals, or hospital emergency rooms. These settings are most able to provide care to the client in the event of a backlog."

Another problem as seen by mental health professionals is that these evaluations become very expensive for mental health centers. Having no contract with the police, the mental health center must attempt to collect for the evaluation from social services or an insurance company. If the individual has no insurance, or is ineligible for support from social services, then the costs of evaluation must be born by the mental health center since DMH does not pay for services provided to unenrolled (unadmitted) clients. The other side of the argument is that mental health centers are supported with public funds for the purpose of serving the mental health needs of all individuals within their catchment area, with charges for services based on the individual's ability to pay.

One way some mental health professionals reduce the cost is to conduct the assessment by telephone. Mental health respondents tended to call these telephone interviews "screenings," while police officers called them telephone evaluations. The respondents overwhelmingly (96.2 percent) felt that telephone evaluations are inadequate.

SURVEY RESPONDENT RECOMMENDATIONS

- Mental health evaluations should be available on a 24 hour basis.
- Mental health centers should rely on better qualified personnel to conduct evaluations.

EVALUATION - TREATMENT OR RELEASE

Law enforcement's most strongly felt problem with the mental health system is that persons referred for evaluation are back on the street almost immediately - "before I get back to the department." Law enforcement respondents felt that this problem is the result of several factors. Probably most important is the fact that the person has calmed down and been somewhat stabilized by the time that the officer transports the person to the mental health center or emergency room. For example, a police officer is called to the scene where a man is irrational, has a gun and is threatening his life and others. The police officer takes the gun away and removes the person from the aggravating situation. By the time the mental health worker sees the person in a "sterile environment" to evaluate him, he has calmed down and is no longer seen as an imminent danger to himself or others. However, when he is released and returns to the situation he may again decompensate and become dangerous, and the police are called again. See the case descriptions in Appendix C for a further illustration of this case.

Law enforcement also felt that their input regarding the incident and the individual's behavior is often not requested or is ignored, even though both the literature review and survey results show a consensus on the importance of offense related variables in assessing dangerousness.

Several law enforcement respondents also expressed a concern about the qualifications of some of the mental health workers who do the evaluations. There was a feeling in some areas of the state that the mental health centers assigned evaluations to less experienced people.

Mental health agencies, on the other hand, felt that often law enforcement agencies make inappropriate referrals. This issue is related to the earlier discussion

about dangerousness and mental illness indicators. For example, while 57 percent of the criminal justice practitioners considered bizarre behavior as a good indicator of mental illness, only 14 percent of the mental health professionals held that same view.

Law enforcement respondents also indicated that often they are not provided feedback regarding the treatment or release of the individual they referred to mental health. Several law enforcement officers felt that if the mental health worker does not think that the referral is appropriate, the law enforcement agency should be notified prior to release. This would give them the opportunity to hold the person and file criminal charges if appropriate, and to respond to criticism from the community about the release of the person.

Mental health professionals felt that at times the criminal justice system requests special services such as immediate evaluations and treatment of criminal justice referrals without providing funding for the provision of these services. Community mental health centers are under considerable pressure to generate local funding sources, not only to expand services, but also to replace state and federal funds. Limited inpatient care resources may also affect the mental health worker's decision to release the individual.

There have been attempts to resolve some of these issues in certain areas of the state. For example, the law enforcement agencies and the mental health center in Jefferson County recently negotiated a contract for services to be billed to the law enforcement agencies per unit of service provided. The following are the essential elements of the contract:

1. The Mental Health Center shall staff a 24 hour, seven day a week, emergency unit at a central location.
2. The Mental Health Center shall provide face to face evaluations by qualified staff at the central location.
3. Face to face evaluations will be provided to all persons brought to the unit by any peace officer commissioned by any jurisdiction within the county.
4. The face to face evaluations will be performed within a reasonable time of the officer's arrival. Reasonable time in this context should not exceed forty-five (45) minutes.
5. The Center will be attentive to police input, will consider the aspect of danger and public safety.
6. The center shall provide feedback to the police agencies of evaluation results on a case by case basis.
7. The center shall work with the police agencies of all county municipalities and the Sheriff to establish appropriate liaison and review procedures of the services to be provided.

SURVEY RESPONDENT RECOMMENDATIONS

- Mental health centers should rely on better qualified personnel to conduct evaluations.

- Mental health should take input from law enforcement officers regarding the behavior of the offender especially regarding the nature and circumstances of the offense.

- Mental health agencies should notify law enforcement agencies prior to releasing client - law enforcement may want to pursue criminal charges.

TASK FORCE RECOMMENDATIONS

- STATUTE 17-10-107 (1) SHOULD BE CHANGED TO REQUIRE SHORT TERM TREATMENT IF THE PERSON HAS BEEN EVALUATED AND MEETS THE CONDITIONS FOR CERTIFICATION. THE STATUTE SHOULD READ: "If a person detained for seventy-two hours under the provisions of section 27-10-105 or a respondent under court order for evaluation pursuant to section 27-10-106 has received an evaluation he *shall* be certified for not more than three months of short term treatment under the following conditions: (a) The professional staff of the agency or facility providing 72 hour treatment and evaluation has analyzed the person's condition and has found the person is mentally ill and, as a result of mental illness, a danger to others or to himself or gravely disabled; (b) The person has been advised of the availability of, but has not accepted, voluntary treatment; but, if reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, his acceptance of voluntary treatment should not preclude certification; (c) The facility which will provide short term treatment has been designated or approved by the executive director to provide such treatment.

- THE 72 HOUR HOLD SHOULD BE EXPANDED TO UP TO SEVEN DAYS.

THE MENTALLY ILL IN JAIL

Jail is a familiar place to many mentally ill persons. Police may jail persons who appear to be mentally ill and, as a result of such mental illness, appear to be an imminent danger to others or to themselves or appear to be gravely disabled, for 24 hours excluding Saturdays, Sundays and holidays if no approved facility is available (27-10-105 (1.1)). Jailed offenders presenting symptoms of mental illness may be handled in several ways:

1. Charges may be dismissed in order to allow civil commitment.

2. The court may order civil commitment with charges pending (27-10-123).

3. The court may order commitment as a condition of probation, parole deferring prosecution or judgment.

4. The person may be held in jail and charged with the offense and require mental health services.

Holding the mentally ill in jail creates many problems which threaten to intensify over the next few years without corrective action.

Some of these problems have already been discussed, however, it is worth reviewing them. The problems include:

1. Inadequate facilities

2. Inadequately trained staff

3. Overcrowded facilities

4. High stress environment

5. Liability

6. Transportation

A person taken into custody under 27-10-105 may be jailed for 24 hours (excluding Saturdays, Sundays and holidays) if no other suitable place of confinement for treatment and evaluation is readily available. However, certain conditions must be met:

1. The person shall be detained separately from charged or convicted offenders.

2. The person must be examined every twelve hours by a peace officer, nurse, or physician or by an appropriate staff professional of the nearest designated or approved mental health treatment facility.

Many jails in Colorado, especially in the rural areas, do not have the facilities and staff to comply with these conditions. They may lack space for segregation, and several jails do not provide 24 hour staff supervision of the jail. In addition, few jails have mental health professionals on their staffs and most jail personnel receive little or no training on how to handle mental health problems.

According to a survey of county jails completed in January 1981 by the Colorado Jail Standards/Criteria Commission, the condition of over 20 percent of these jails was rated as poor or very poor. Most of the poorly rated jails are located in rural areas. Approximately one third of the county jails had been sued or had suits pending at that time. Many of the suits involved overcrowding as well as other general conditions.

A study of "Psychotics in Jail" in Boulder County was presented by Richard Warner, Medical Director of the Mental Health Center of Boulder, Inc. in the winter of 1981. A study of prisoners in the Denver County Jail and Ward 18 is currently being conducted by the Denver Anti-Crime Council. In addition, several cases involving dangerous mentally ill persons in a rural county were reviewed and the problems identified are summarized. These studies are presented on the following pages and are useful in further defining and illustrating the problems identified in the survey of practitioners.

Boulder County Jail

Unlike many jails in Colorado, the Boulder County Jail has trained nursing and professional mental health staff, and the Mental Health Center of Boulder County provides a program of mental health services to jail inmates and con-

sultation to correctional staff. These services include 24 hour crisis response, drug abuse counseling, and twice weekly psychiatric treatment and evaluation provided by a psychiatrist and mental health professional.

During the period from October 1979 through September 1980, 119 individuals were evaluated by the jail psychiatry team, and 71 were found to be psychotic, possibly psychotic or suffering from an organic brain syndrome. A small number of acutely psychotic people were seen by the Mental Health Center crisis services in the jail and immediately transferred elsewhere. The 71 non-acute psychotics account for only 1.3 percent of the jail admissions during that year, but because of their extended length of stay they represented approximately ten percent of the inmate population. This figure compares to national figures which show that up to eight percent of the population in U.S. jails are psychotic offenders, and that they are more likely to be detained longer than other lawbreakers. Table shows the type of offenses for which psychotic individuals were detained in the jail.

Fewer than half of the non-acute psychotics evaluated were transferred to treatment elsewhere; the remainder stayed in jail. Half of the non-acute psychotics seen in the Boulder County Jail remained there because they were considered too mildly disturbed, in some cases (24) for involuntary treatment, and in other cases (11) for residential care. Three patients remained in jail because they were too violent for community placement and long term state hospital care was not available.

The detention of psychotics in jail and, in particular, the small group of violent individuals, places a burden upon the correctional system. Staff and other inmates suffer from their unpredictable behavior and the patients themselves deteriorate. For example, one patient in his early 30s for several years has held delusional beliefs that he is being pursued by "junkies," and that metallic implants in his brain cause him mental anguish. Although at times he becomes suicidal and retreats to his room for weeks at a time out of fear of others, for most of the period of his psychosis he has lived an active and satisfactory life without psychiatric treatment. In jail he was seen as delusional but not gravely disabled or a danger to himself or others. He did not, therefore, meet the criteria for involuntary treatment under the Colorado mental illness statute and he refused voluntary treatment. After several weeks in jail, the stress of detention brought about a worsening in his psychosis, inducing features of volatility, fearfulness, disorganized thinking and suicidal ideas. At this point he was transferred to a hospital for involuntary treatment.

Three violent psychotics were treated in the jail because, after several attempts at hospital and residential treatment, the patients had proved too violent and destructive for community care. The proper setting for these people was considered to be long term institutional care in a secure psychiatric facility such as a state hospital. However, Fort Logan Mental Health Center had a waiting list of around 100 patients during this period. Placing these three patients in a private psychiatric hospital was considered too expensive and would have led to the laying off of one Mental Health Center staff member for each month of hospitalization.

Denver City and County Jail

A study is currently being conducted by the Denver Anti-Crime Council (DACC)

TABLE 10

OFFENSES FOR WHICH PSYCHOTIC INDIVIDUALS SEEN IN BOULDER COUNTY JAIL BETWEEN OCTOBER 1979 AND SEPTEMBER 1980 WERE DETAINED

OFFENSE	NUMBER	PERCENTAGE
Major		
Burglary	9	12
Assault	8	11
Sexual Assault	6	8
Felony Menacing	3	4
Arson	2	3
Reckless Endangerment	2	3
Theft	2	3
Carrying Concealed Weapon	1	1
Criminal Impersonation	1	1
Extortion	1	1
Kidnapping	1	1
Prohibited Use of Weapon	1	1
Total Major Offenses	37	50
Minor		
Trespass	15	20
Harassment	4	5
Failure to Appear	4	5
Bond Revocation	1	1
Driving Under Suspension	1	1
Indecency	1	1
Possession of Marijuana	1	1
Possession of Open Container of Liquor	1	1
Violation of Deferred Sentence	1	1
Violation of Restraining Order	1	1
Total Minor Offenses	30	41
Not Known	6	9

of the mentally disturbed offenders held in the Denver jails. Preliminary data from the study shows that 1,031 people were booked into the Denver County Jail with possible mental health problems from January 1980 to June 1981.

The following table shows the reason that the clients were being held in jail.

Violent crime	9.3%
Non-violent felony/misdemeanor	28.8
Ordinance violation	61.0
Hold for other jurisdiction	10.0

DACC also reviewed a small sample (44 cases) of clinical records at the infirmary at the jail to look at the diagnoses of these clients. Forty-two percent were diagnosed as severe/chronic, 12.5 percent as acute and 2.3 percent as organic brain syndrome.

Five hundred and ninety-two of these cases or 57.4 percent were transferred to Ward 18 at Denver General Hospital. The balance of 439 were treated at the jail. The average length of time from arrest to release is 14.8 days. The two charts on the following pages show the disposition of cases.

Rural Jail

An interview was held with a sheriff and mental health center worker of a rural county to review the handling of recent cases involving dangerous mentally ill persons. Two cases are presented here which help to illustrate some of the problems found in rural jails. Several additional case descriptions are included in Appendix C.

In the first case, the sheriff's office was called to the scene of a burglary in progress. A 39 year old male was arrested a short distance from the scene and was booked into the county jail for second degree burglary. The individual was diagnosed as a borderline psychotic and spent one month and ten days in the county jail while the mental health center tried to secure a bed for him. During this time the individual created "chaos" in the jail and had to be physically restrained on several occasions. The mental health staff tried on repeated occasions to treat the individual, however, he refused treatment. The individual was then transported to Fort Logan for a 30 day hold with the pending burglary charge. The individual has since escaped from Fort Logan and is still at large.

The second case illustrates the problems related to placement and transportation. The sheriff was called by a neighbor of a man who was trying to start a fire in another person's yard. The sheriff officers picked up the 29 year old male who was displaying very strange and bizarre behavior. This individual was placed in the jail. He had been placed on a 72 hour hold once before in 1978. The mental health unit was called and evaluated the person as possibly paranoid schizophrenic, and medicated the individual since he was displaying violent behavior. The mental health center called "everyone in the state" for placement, but because he was violent, CSH was the only place that would accept him. After spending seven days in jail while placement was being arranged, the individual was transported to Pueblo for a 30 day evaluation on a court order. Four days later the sheriff was called to pick the person up

from CSH and transport him back to his jurisdiction. Two days later the individual became violent again and was transported to St. Joseph's Hospital in Denver on another 72 hour hold. Ten days later the sheriff was called by St. Joseph's and told to come pick the person up and transport him to Fort Logan for further evaluation and possible treatment. Approximately one month later, the individual was once again picked up and transported back to the community for a hearing on a pending assault charge. In total, the sheriff deputies made two round trips to Pueblo, four round trips to Denver, at a cost to the county of approximately $480 in salaries; 1648 miles at 20 cents per mile equalling $329; eight visits from mental health for evaluation and medication at a cost of approximately $503, plus the cost of seven days in jail time.

In another case, an individual was sent to CSH for an evaluation. He was later returned to jail to await trial. CSH mails their report directly to the District Court which may take several days. As a result, neither his staff nor the local mental health center are informed of the results of the evaluation and instructions regarding treatment or medication while the individual is in jail.

These studies and the cases presented illustrate several issues which were also identified through the survey.

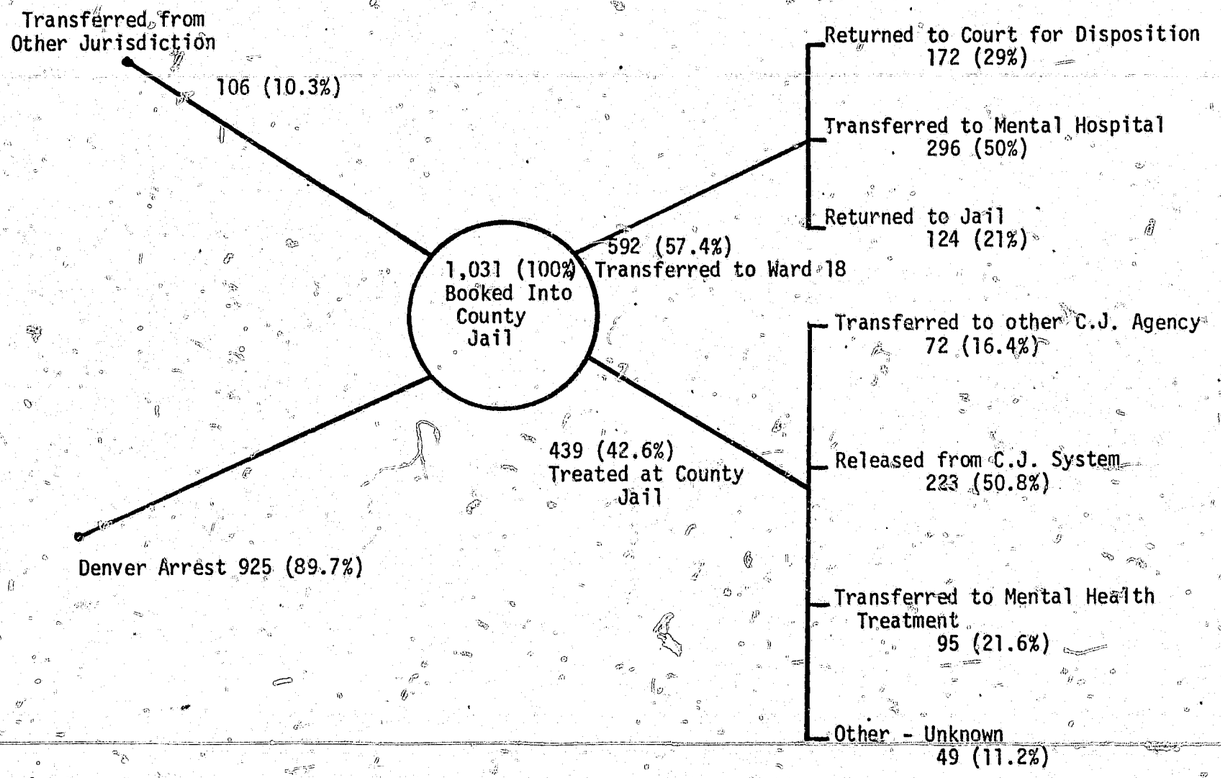
- In many areas of the state, jail is the only alternative available for holding dangerous mentally ill.
- Clients are held in jail because the state hospitals are full.
- Many jails, especially in the rural areas, do not have adequate facilities and trained staff to confine the mentally ill. When a dangerous person is held and has to be segregated it creates crowding problems for the rest of the prisoners.
- Mental health problems often become worse while the individual is held in jail.
- Transporting clients to mental health facilities and back to the local jurisdiction for hearings, etc. creates problems for sheriff's departments, especially in rural areas where mental health facilities are great distances away and manpower is very limited.
- Lack of adequate mental health services in jails increases the likelihood of lawsuits.

SURVEY RESPONDENT AND STUDY RECOMMENDATIONS

- Mental health staff and programs should be available in all jails.
- Jails should have a place to segregate mentally ill offenders, as required by law.
- Mental health facilities should provide instructions to jailers on treatment, medication and care of mentally ill while they are held in jail.

Cases with Possible Mental Problems Entering Denver Jail in 18 Months

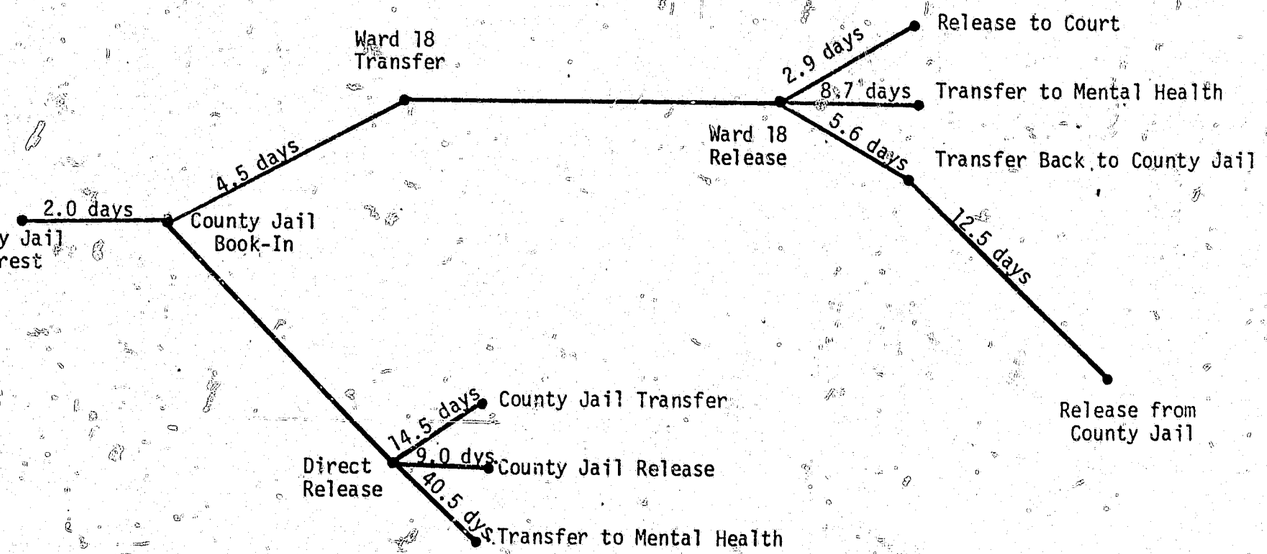
Denver Anti-Crime Council
August 19, 1981



Denver Anti-Crime Council
August 19, 1981

Mentally Disturbed Offender Case Processing

January 1980 to June 1981



Median Days:

In Ward 18 - 5.6 Days
Arrest to Release - 14.8 Days

- Treatment instructions for individuals transferred to the local jail from the state hospitals for hearings should be provided to the jail staff and/or the local mental health center prior to or when the individual is transferred.

- Revise mental illness statute to clarify the grey areas where the need to enforce treatment is not presently clear. A necessary change in the statute would combine the criteria for certification with those for incompetency to refuse medication. This revision would insure that treatment agencies could not be left in the position of detaining patients whom they were subsequently enjoined from treating.

- For the group of psychotic (15 percent of those evaluated in the Boulder County Jail) whose condition does not appear to warrant residential treatment, but whom the judge is unwilling to release for outpatient treatment, a local criminal justice psychiatric unit should be developed to provide needed treatment. Such a unit could also provide a suitable setting for those psychotics who do not meet the criteria for involuntary treatment.

- There should be an expansion of the number of non-forensic state hospital beds for the severely disturbed psychotics who are too violent for community placement.

- Everything possible should be done to speed the judicial process for those offenders whose circumstances clearly require placement in the state hospital forensic unit. Improved communication between mental health services, attorneys and the courts, within the limits of client confidentiality, may allow a reduction of the time that these seriously disturbed psychotics remain in jail.

TASK FORCE RECOMMENDATIONS

- MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD BE AVAILABLE TO ALL JAILS TO PROVIDE EVALUATIONS AND TREATMENT SERVICES.

PLACEMENT AND TREATMENT ISSUES

"Mental health care should ensure that there is a continuity of relevant care from the initiation of services until the client terminates from service and that there are no gaps in service that will be detrimental to the welfare of the client." (State of Colorado Mental Health Plan, 1980-1985, "Principles of Mental Health Care," p. 11.4).

The mental health system's ability to act upon the principle quoted above is severely limited by funding constraints and organizational problems. The waiting list at Fort Logan and the placement of dangerous patients on the surgical ward at CSH give evidence that the system is not functioning properly.

BED SHORTAGE

One of the most frequently cited problems in providing services for the dangerous mentally ill is the lack of adequate bedspace at the two state hospitals. Survey respondents were asked about the effect of overcrowding on

placement decisions. If the state treatment facilities are full, what is the next best alternative and what can be done with these people. Some respondents indicated more than one alternative.

45.5% - Jail
15.6 - Intensive outpatient treatment by mental health center
14.4 - Local hospital
7.2 - Private institution
12.6 - Other community treatment or facilities
2.4 - Release

Jail is the only alternative available in many of the rural areas of the state. Emergency rooms in local hospitals are often reluctant to take these people because they are disruptive and potentially violent.

There is no longer a waiting list at Fort Logan. On July 1, 1981 Fort Logan allocated beds to the mental health centers, from two to nine beds per center. Therefore, the waiting list is kept by the individual centers and an accurate count is not available. In addition, 24 high risk beds at Fort Logan should be available by October 1, 1981. These changes should offset some of the problems related to inadequate bedspace. However, until the bed shortage problem is completely resolved, it is important to look at the type of people who are awaiting admission.

A study was completed by Dick Ellis of FLMHC on the 115 clients on the Fort Logan waiting list as of December 19, 1980. The following table shows the number of people on the waiting list by referring center.

TABLE 11

REFERRING CENTER	N	%	% FY 79-80 ADMITS*
Colorado West	1	0.9	11.0
Larimer	0	0.0	1.7
Weld	4	3.8	1.0
Centennial	3	2.8	5.2
Bethesda	3	2.8	1.7
Arapahoe	4	3.8	21.4
Adams	6	5.7	1.7
Jefferson	14	13.2	7.3
Boulder	10	9.4	2.7
Park East	12	11.3	3.7
Denver Health & Hospitals	44	41.5	10.8
Aurora	4	3.8	23.0
	106	99.9	100.1

* Percent of adult clients admitted from Fort Logan C/A = N = 482

Table 12 shows the length of time on the waiting list. The majority of clients, 59.4 percent, have been on the waiting list for five or more months. An additional 26.4 percent have been on the list for two to four months.

TABLE 12

LENGTH OF TIME ON LIST

Number of Months	N	%	
1	15	14.2	
2	11	10.4	
3	5	4.7	26.4%
4	12	11.3	
5	9	8.5	
6	11	10.4	
7	17	16.0	59.4%
8	23	21.7	
9	3	2.8	
TOTAL	106	100.0	

The clients on the waiting list are very similar to those admitted and to those in treatment in Fort Logan last fiscal year. The majority of them are schizophrenic (61.3 percent) or personality disorders (13.2 percent), which were also the leading diagnostic admission groups. A comparison with the adult admissions to the same community mental health centers (those in Fort Logan's Service Area), however, indicates that these are not typical of clients treated in those facilities. For example, only 8.1 percent of the community mental health center client caseload are diagnosed schizophrenic. Severity in combination with diagnosis determines whether a client is referred to Fort Logan, as shown in Table 14.

TABLE 13

Diagnosis	N	%	FY 79-80 Admits	%FY 79-80 CMHC Admits*
Schizophrenia	65	61.3	59.2	8.1
Non-Schiz. Psychosis	10	9.4	13.9	2.3
Depressive Neurosis	1	0.9	5.4	16.3
Other	1	0.9	-	6.2
Personality Disorders	14	13.2	17.8	15.3
Transient Situational	1	0.9	1.7	15.7
All Others (incl. Drug, DD)	6	5.7	1.7	34.2
Blank/Unknown	8	7.5	-	1.9
TOTAL	106	99.8		

* FLMHC Catchment Area CMHCs

The following table shows the level of functioning for the clients on the waiting list compared to admissions to FLMHC and to other mental health centers. 96.4 percent of those on the waiting list were moderately or severely disabled compared to 98.8 percent of the FLMHC admissions and 80.9 percent of MHC admissions. 53.5 percent of those on the waiting list were considered to be severely disabled compared to only 11.9 percent of the MHC admissions.

TABLE 14

LEVEL OF FUNCTIONING - SEVERITY INDEX (Σ TOP 3 SCALES)

	Score Range	% Waiting List		% FY 79-80 FL Admits		% FY 79-80 MHC Admits	
	61	0.0		1.0		5.3	
	61-70	2.4		0.2		7.0	
	71-77	1.2		0.0		6.8	
	78	0.0		0.0		0.7	
	79-80	0.0		0.2		3.7	
Moderate	81-90	3.6		1.2		16.3	
	91-100	3.6		3.3		17.8	
	101-110	11.9		7.2	98.8%	18.0	80.9%
	111-120	23.8	96.4%	16.1		12.6	
	121-130	26.2		29.8		7.3	
Severe	131-140	19.0	70.7%	26.9	11.9%	3.7	
	141-150	8.3		14.0		0.9	
	TOTAL	100.0					

Table 15 shows what happens to clients who are waiting for admission to Fort Logan.

TABLE 15

Current Residence	Time on Waiting List 1 Month	2-4 Months	5+ Months
Jail	2	1	1
Private Psych. Hosp.	4	3	2
CPH	3		1
CSH		1	1
DGH		3	1
Nursing Home		2	4
Other 24 Hour		9	10
Home	2	10	18
Out of State		2	4
Suicide Victim			1
Blank/Unknown	4	6	11

Ellis states that most clients on the waiting list are first placed (or remain) in an alternative 24 hour facility. A few remain at home. "A surprisingly large percentage (37%) are still in or have returned to the intensive setting 5-9 months after being placed on the waiting list. Those at home are also at risk; one client died of self-inflicted gunshot wounds. It also should be pointed out that the estimated scores for dangerousness established during the initial interview with the client may not be accurate at a later point in time. For example, two clients from one mental health center, who were on Fort Logan's waiting list, are currently the most disruptive and difficult clients to handle of the center's present client population. Both rated "no" on danger to self and others at admission, and both have gone into crisis since that time and have displayed violent behavior. In one case, the patient hit another person, causing him to need seven stitches. In the other case, the client held a knife to the throat of a receptionist at a doctor's office, and later that day took an overdose. The main point is that most clinicians rate clients on the dangerousness scales in terms of imminent dangerousness to self and others, rather than in terms of trying to determine future dangerousness (Ellis, 1981:9-10).

SURVEY RESPONDENT RECOMMENDATIONS

- Fort Logan should allocate beds on a county by county basis. (Beds were allocated to mental health centers beginning July 1, 1981.)
- Additional in-patient beds should be available.

TASK FORCE RECOMMENDATIONS

Several recommendations were made by the task force regarding the need for additional beds. See an earlier section on Resources.

REVIEW OF COMMITMENTS

There are other problems, however, in addition to those caused by overcrowding. Once the patient has been certified as dangerous as a result of mental illness, the mental health center, the district attorney, the patient's attorney and the court may be involved in placement. Without standard procedures to guide actions of the diverse agencies which participate in mental health decisions, placement and treatment decisions often do not serve the best interests of the client or the public. Problems have been identified in (1) the review process for civil commitments, (2) placement for mental health treatment as a condition of deferred judgment or probation, (3) the patient's right to refuse treatment, (4) secure placement for DMIPs, and (5) placement for the "untreatable" client.

The civil commitment statute, 27-10-107, Certification for short term treatment, provides for court review of all certifications for short term treatment:

> "(6) the respondent for short term treatment or his attorney may at any time file a written request that the certification for short term treatment or the treatment be reviewed by the court or that treatment be on an outpatient basis. If review is requested, the court shall hear the matter within ten days after the request

> and the court shall give notice to the certifying and treating professional person of the time and place thereof. The hearing shall be in accordance with section 27-1-111. At the conclusion of the hearing, the court may enter or confirm the certification for short term treatment, discharge the respondent, or enter any other appropriate order."

The wording and requirements of the statutes create a tendency for technical errors to be made.

Requests for reviews of short term commitments are more frequent in the Denver Metro area and Pueblo. Since the courts in these areas have very heavy caseloads, the review process creates logistical and scheduling problems. Although courts in rural areas have fewer requests for review, scheduling is a problem there also because of the distance factor. The requirement that the hearing be held within ten days requires hurried preparations by mental health centers and county or district attorneys. Coordination of involved parties within the time limit is also difficult, particularly in the rural areas where the judge, public defender, district attorney and mental health center all serve several and not necessarily the same counties. If the ten day deadline is not met, the certification process must be repeated from the beginning. A judicial survey respondent suggested that the review process be made automatic so that preparations could be routinized.

TASK FORCE RECOMMENDATIONS

- A MULTI-DISCIPLINARY COMMITTEE SHOULD BE ESTABLISHED TO REVISE AND DEVELOP MODEL STATUTES.
  - DRAFT A STATUTE TO CLARIFY THE GREY AREAS WHERE THE NEED TO ENFORCE MEDICATION IS NOT PRESENTLY CLEAR FOR THOSE INDIVIDUALS WHO ARE VIOLENT TOWARDS OTHERS. A NECESSARY CHANGE IN THE STATUTE WOULD INTRODUCE A PROCEDURE WITH CRITERIA SIMILAR TO THOSE IN INCOMPETENCY PROCEEDINGS. THIS SHOULD BE INCLUDED IN WITH OTHER STATUTES TO BE LOOKED AT AND POSSIBLY CHANGED.

DEFERRED PROSECUTIONS AND SENTENCES

Sections 16-7-402 and 16-11-204, CRS 1973, as amended, provide that if an accused or convicted criminal appears to require mental health treatment, the judge may as a condition of probation, or as a condition for deferred prosecution or deferred sentencing, require the criminal or alleged criminal to obtain mental health treatment. The judge may issue an order requiring the state hospital to treat the client for up to a year.

The Colorado State Auditors recently completed a performance audit of the Department of Institutions. They found that at any one time up to one out of five inpatient beds at Fort Logan Mental Health Center may be occupied by clients on deferred prosecution or deferred sentence. The number of deferred judgment clients admitted in FY 1979/80 was 20 and was estimated to be 24 in FY 1980/81. The auditors also found that deferred judgment clients were hospitalized an average of 2.4 times longer than other adult clients, or 76 days compared to 31 days.

Fort Logan objects to these court ordered placements on several grounds:

1. The deferred prosecution and sentencing process does not require an examination and findings of mental illness.
2. There is no definition of "mental condition" or "rehabilitation treatment," and no standards or procedures to be followed.

A treatment team (Adult Team I) reviewed the list of 115 for the period of July 1, 1977 through December 31, 1980 and gave their impressions of their appropriateness/inappropriateness for admission to Fort Logan. Staff were able to impressionistically evaluate 52 of the 115 admissions. The following is a breakdown of recommended placement for these clients.

TABLE 16

APPROPRIATE PLACEMENT FOR DEFERRED JUDGMENTS

Appropriate/ Not Appropriate	Deferred Prosecution		Conditions of Probation		Percent of Total	N
Appropriately placed	10	19.2%	12	23.0%	42	22
Jail	4	7.6	4	7.6	15	8
Alcoholism/Drug out patient	2	3.8			4	2
Community Corrections	4	7.7	3	5.8	14	7
Long Term Custodial Care	2	3.8			4	2
CSH Forensic Unit	9	17.3	2	3.8	21	11
	31		21		100*	52

*Rounded to 100%

Of the 52 that staff was able to rate as to appropriateness of admission to Fort Logan, only 22 of the 52 (42.3 percent) were felt to be appropriate admissions. As shown above, treatment staff believe that many deferred judgment patients would be more appropriately placed in a correctional setting. Survey respondents report that this group of patients disrupts operations, resists treatment, and interferes with the recovery of other patients.

Also, mental health professionals and the court may differently interpret the provisions of the statute regarding length of treatment. Sutherland Miller (1980) discussed this issue:

> "Judges appear to interpret the Colorado statute 16-7-402 to mean that they can place someone in a mental health facility for a year. Mental health facilities interpret the same statute to say that the person can stay no longer than a year. From these interpretations and their uses flow widely different expectations.
>
> Judges often perceive their actions as sentencing the person for a definite period of time. They expect the mental health facility to incarcerate the person for a year, make sure no escapes occur, cure the illness, and release only with their permission.
>
> Mental health facilities behave as if the person becomes a patient once in their program. To them this means the person will be treated like any other patient, subject to the same rules and risks. Release decisions will be made by them strictly on the basis of whether the person is ready to function outside the institution in a reasonable manner according to mental health standards" (p.38).

The different interpretations of the provisions of 16-7-402 reflect other problems discussed elsewhere in this report.

1. No criteria or procedures establishing clear responsibility for commitment and release of dangerous mentally persons. In some of these cases the courts have become involved through the efforts of community mental health centers to get certain individuals committed. The state hospital, in one case, had evaluated and released the client several times. Overcrowding makes it necessary for the state hospitals to assess "relative" dangerousness, thus their assessment may differ from that of the community mental health center.

2. Different values and perspectives of the participating agencies. The prevailing theory of mental health therapy says that coersion precludes effective treatment. The court, however, needs dependable alternatives for placement in cases involving the mentally ill offender.

These problems are also reflected in community placement decisions. Offenders may be required, as a condition of a deferred judgment or probation, to accept mental health treatment as an outpatient at a community mental health center. Very few mental health professionals are trained to work with assaultive or extremely resistant patients. One respondent described a case in which the patient had to be found and brought in by the police and kept in handcuffs under police guard during the therapy session. Community mental health centers have been criticized for not making stronger efforts to find, treat and supervise these clients.

Survey respondents were asked to agree or disagree with a series of statements about deferred sentences. The results are presented in the following tables.

CONTINUED

1 OF 3

TABLE 17

A DEFERRED SENTENCE IS NOT AN EFFECTIVE MEANS OF INSURING TREATMENT FOR A DANGEROUS MENTALLY ILL PERSON

61.6 %	Agreed
29.8%	Disagreed
8.6 %	Had No Opinion

Feelings about the effectiveness of deferred sentences varied by type of agency the respondent was associated with. Public defenders support the use of deferred sentences. The judiciary and the district attorneys tended to feel they were effective. The majority of respondents from other agencies did not feel they were effective.

TABLE 18

THE DANGEROUS MENTALLY ILL PERSON IS NOT ADEQUATELY SUPERVISED WHEN ON A DEFERRED SENTENCE

74.7 %	Agreed or Strongly Agreed
8.9 %	Disagreed
16.4 %	Had No Opinion

TABLE 19

THERAPISTS INVOLVED IN TREATING DANGEROUS MENTALLY ILL PERSONS SERVING A DEFERRED SENTENCE SHOULD NOT BE REQUIRED TO MONITOR COMPLIANCE WITH THE TERMS OF THE SENTENCE

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	16	39.0%	11	15.1%	8	24.2%	35	23.8%
Disagree	25	61.0	62	84.9	25	75.8	112	76.2
	41		73		33		147	

Criminal Justice personnel are more likely to disagree with the statement than mental health practitioners. However, 61 percent of the mental health practitioners also disagreed.

SURVEY RESPONDENT RECOMMENDATIONS

- Deferred sentences should not be used for the dangerous mentally ill.
- If deferred sentences are used, their use should be properly monitored. Clients should be closely supervised and provided with effective treatment.

46.7 percent of the respondents who commented believed that deferred sentences could be a good tool if properly used, especially for the young, first time offender. Specific suggestions included:

- strict criteria
- close supervision
- prior consultation with mental health and make mental health treatment a part of the terms
- recidivism should be considered in the decision
- should be supervised and administered by the Department of Corrections.

TASK FORCE RECOMMENDATIONS

No recommendations were made. However, the Division of Mental Health discussed with the task force the fact that they are planning to request an amendment to Section 16-7-402 to require a psychiatric examination to determine need for treatment, to allow professional assessment of length of treatment needed followed by release of the patient back to the court, and to clarify some of the language.

THE RIGHT TO REFUSE TREATMENT

As a result of Goedecke v. State Department of Institutions, the court became involved in another mental health issue - the right to refuse treatment. A person may be committed as dangerous to others as a result of mental illness without losing the right to refuse anti-psychotic medications or other types of therapy. Thus, to involuntarily detain and involuntarily treat, separate legal actions are required. This process has become an impediment to commitment and treatment in cases where mental health centers do not have the time and money to spend on case preparation. The violent acts of many dangerous mentally ill individuals can be controlled with medication. The right to refuse treatment can lead to disruptive and violent behavior in the hospital setting and the jail, requiring additional staff resources to control the individual. Also, as discussed earlier, the dangerous persons who are controlled while receiving treatment and medication in the hospital and are then released into the community become threats to themselves and/or others when they refuse to continue the treatment in the community.

The survey included several items to measure respondents' attitudes toward the right to refuse treatment. Although attitudes varied with client status, the majority opinion is opposed to the patient's right to refuse treatment. The following table shows the results by agency type.

TABLE 20

PERCENTAGE OF RESPONDENTS BY TYPE OF AGENCY
WHICH AGREE THAT CLIENTS HAVE A RIGHT TO REFUSE TREATMENT

	Awaiting Incompetency Hearing in Jail		Voluntarily Admitted		Involuntarily Certified		Conditionally Released	
Mental Health	11	25.0%	21	48.8%	6	12.8%	10	21.3%
Law Enforcement	43	58.1	26	35.1	8	11.0	8	11.0
Judiciary/DA/Attys	16	48.5	20	55.6	11	28.9	3	8.6
% of all agencies	70	46.4	67	43.8	25	15.8	21	13.5

Responses considered by client status, however, show that most law enforcement agencies agree that those awaiting competency hearings in jail should have the right to refuse treatment, and slightly over half of the judicial respondents agree that the voluntarily admitted should have the right to refuse treatment. As can be seen, only 25 percent of the mental health respondents agreed that those awaiting an incompetency hearing in jail should have the right to refuse treatment, and 35 percent of the law enforcement respondents agreed that patients voluntarily admitted should have this right. These responses reflect some of the differences in philosophy already discussed. Mental health workers are less inclined to support the right to refuse treatment for jailed offenders, law enforcement respondents, for patients voluntarily admitted. One explanation given in interviews for this attitude is "why admit them and use bedspace if they are not going to be treated." A comparison between mental health and judicial responses across the categories shows their differences. The judiciary are much more inclined to support the right to refuse treatment except for the conditionally released patient. Mental health professionals who supported this right for the conditionally released explained that although the right should be respected, the patient should be recommitted if he exercises it.

A July 31, 1981 report by the Disability Law Committee of the Colorado Bar Association also discusses how the Goedecke decision has affected the system:

> "The most recent contributing factor to the funding problem has been the implementation of the right to refuse medication, announced by the Colorado Supreme Court in Goedecke v. State Department of Institutions, ____Colo.____, 603 P.2d 123 (1979). The right to refuse has had a significant impact on the resources of the mental health system as a whole, as found in a recent article in the Denver Law Journal. Shavill, 'Patient's Rights vs. Patient's Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado', 58:3 Denver Law Journal (1981). Patients who refuse treatment disrupt the treatment milieu, and are sometimes out of control and thus violent. This requires extra staff time (Shavill, supra at 593). Further, treatment is disrupted and hospital stays are longer (Id. at 602) which both increases the cost of treatment dramatically (an average hospital

> day in the Denver metropolitan area costs $165) and prolongs the suffering of the patient. Hospital stays are also lengthened and costs increased by delays of up to one to three weeks in getting to court for a medication order (Id. at 598)."

But as Miller (1980) and others have noted, the right to refuse treatment seems to be firmly established. Thus, a more efficient means of administering Goedecke is needed. One judge interviewed felt that Goedecke could be handled administratively. Another suggestion was that commitment and treatment hearings be combined. As shown in the following table, however, respondents felt that the courts should maintain at least their current level of involvement.

TABLE 21

THE COURTS SHOULD BE LESS INVOLVED
IN TREATMENT DECISIONS FOR DMIPS

	Mental Health		Law Enforcement		Judiciary/DA		Total	
Agree	18	40.9%	25	35.7%	8	22.2%	51	34.0%
Disagree	26	59.1	45	64.3	28	77.8	99	66.0
	44	29.3	70	46.7	36	24.0	150	100.0

Many survey respondents felt that if an individual had committed an offense the district attorney should prosecute if he refused treatment. Respondents were asked to agree or disagree with the statement that district attorneys should prosecute on criminal charges all mentally ill persons who refuse treatment. The results are shown in the following table.

TABLE 22

THE DISTRICT ATTORNEY SHOULD PROSECUTE ON CRIMINAL CHARGES
ALL MENTALLY ILL PERSONS WHO REFUSE TREATMENT

	Agree	Disagree	No Opinion
Mental Health	70.5%		
Law Enforcement	68.9		
Judiciary	57.1		
Public Defenders		100.0	
District Attorneys		72.7	
Total	59.1	34.0	6.0%

There was a wide divergence in opinion by agency type. Public defenders were unanimously opposed to this notion. Mental health practitioners were the most likely of any group to agree with this statement.

TASK FORCE RECOMMENDATIONS

- THERE SHOULD BE A MULTI-DISCIPLINARY COMMITTEE ESTABLISHED TO REVISE CURRENT STATUTES AND TO DEVELOP MODEL STATUTES.

SECURITY

As indicated in the quote from the Colorado Bar Association report, security is an ever present concern in the treatment of dangerous mentally ill persons. Respondents were asked for their opinion on desirable security levels. Almost one third see a maximum security level as desirable. As the table shows, more law enforcement respondents favored maximum security than mental health or court related agencies.

TABLE 23

SHOULD THE SECURITY LEVEL FOR HOLDING DANGEROUS MENTALLY ILL PERSONS BE MINIMUM, MEDIUM OR MAXIMUM

	Mental Health		Law Enforcement		Judiciary		Total	
Minimum	7	15.9%	33	44.6%	8	25.8%	48	32.2%
Medium	3	6.8	1	1.4	0		4	2.7
Maximum	0		0		0		0	
Based on Indiv. Assessment	34	77.3	40	54.0	23	74.2	97	65.1
	44		74		31		149	

Respondents were also asked for their perceptions of security at the state hospital. The results are shown in the following table.

TABLE 24

SECURITY LEVELS ASSIGNED TO FORENSIC PATIENTS AT THE STATE HOSPITAL ARE ADEQUATE

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	16	66.7%	8	19.5%	7	38.9%	31	37.3%
Disagree	8	33.3	33	80.5	11	61.1	52	62.7
	24	28.9	41	49.4	18	21.7	83	100.0

The table shows that most mental health respondents perceive security as adequate, with most disagreement coming from law enforcement and court related respondents.

A State Security Study was completed in the Spring of 1981 by Wilson, Rose and Ellis of the Division of Mental Health as a result of one of Miller's (1980) recommendations. The following table shows the incidence of unauthorized departures and return rate for involuntary patients, those classified as "return urgent", those on Maximum and Medium Forensic Units, and many of those on Minimum Forensic Units who might be considered potentially dangerous.

TABLE 25

FLMHC AND CSH ADULTS SERVED, INCIDENCE OF UNAUTHORIZED DEPARTURES (UAD) AND RETURN RATE FY 1978-79

	Patients Served N	Unauthorized Departures (UAD) N	Ratio UAD/pt served	Returned N	Returned %
Fort Logan Involuntary	547	92	.17	71	77
Colorado State Hospital Involuntary	758	150	.20	118	79
Forensic	656	69*	.10	64	93
Totals	1961	311	.16	253	81

FY 1979-80

	Patients Served N	Unauthorized Departures (UAD) N	Ratio UAD/pt served	Returned N	Returned %
Fort Logan Involuntary	455	102	.22	83	81
Colorado State Hospital Involuntary	1113	175	.16	149	85
Forensic	682	51*	.07	48	94
Totals	2250	328	.15	280	85

*None of these occurred from Maximum Security Units.

According to the study, the table clearly demonstrates a very low ratio of departures to patients served which would be even lower with an unduplicated patient count. However, "this ratio has decreased at CSH from FY78-79 to FY 79-80 while the number of patients served has increased, perhaps due to the recent tightening of security practices and heightened awareness of the consequences of misjudged risks. The results are less promising for Fort

Logan, where the numbers are reversed" (p.19). Within three days, 79-85 percent of unauthorized departures have returned. By the end of a week, 92-94 percent are back.

The study describes complexities of the security issue in the context of patients rights legislation, changing treatment philosophies, and physical structure/staffing constraints.

The main theme of the study is the integration of security practices with treatment. The study describes how the historical development of CSH and Fort Logan have led to their present operation. CSH was constructed as a custodial institution, went through deinstitutionalization in the 60s, and changing treatment philosophy in the 70s. Fort Logan, which opened in 1960, was designed as a model mental health treatment facility, with open door units allowing maximum patient movement and freedom. Some units have since been converted to closed units which are more secure, but "because of the patchwork nature of these changes, these buildings cannot be considered secure in the same sense that the old state hospital buildings or a modern jail might be" (p. 26).

Thus, the "closed" treatment philosophy of CSH and the "open" treatment philosophy of Fort Logan have changed and come together. Differences remain, however, as a result of the physical structures and different types of patients. At first, CSH was responsible for chronic patients, criminally committed patients, and extremely violent patients. As Fort Logan has assumed more of the Northern Colorado caseload, however, its population is becoming more like that at CSH.

The patients rights laws have been largely responsible for the integration of treatment and security. Following are several quotes which pertain to the effect of their implementation.

> On The Right to Treatment: "The thrust for accountability and associated requirements for documentation developed in conjunction with the right to treatment...have placed unmeasured increased demand on staff. Staffing levels have not increased in proportion to the requirements for documentation, hence the very documentation that purports to assure quality of care may very well result in increased quality of records but decreased quantity of treatment."
>
> "It is a paradoxical 'catch-22' situation for staff when they are required to provide treatment to someone who seems for most practical purposes 'untreatable.' When such individuals must be treated as required by law, it should be in specially designed and staffed units." (p. 35)
>
> On Due Process: "The principle that 'nothing of value be taken from a person without due process of law' has been applied to movement of forensic patients to more secure settings. Such moves are not made capriciously nor on some vague suspicion of risk. In addition, secure units are usually full and the clinical judgment frequently holds that continuity of treatment is better served by not moving a patient unnecessarily. Unfortunately, this can result in not moving patients to more secure areas in time to prevent acting out. The reluctance to transfer patients to a less secure area even when clinically indicated is partly related to the regulatory and clinical difficulty of reversing the move even if it turns out to be in error." (p. 37-38)
>
> On Use of Restraint and Seclusion: "It has been estimated...that meeting the minimum (regulatory) requirements of R/S requires a minimum of five staff hours per day. This alone, regardless of common humanitarian motives, leads staff to view R/S as a last resort." (p. 39)
>
> On the Right to Refuse Treatment: "...current case law and associated hospital regulations require that a court hearing on the issue of medication be held if the patient refuses medication and the physician in charge feels that medication is essential to treatment. From our discussions with staff, it appears that there is some variation among courts as to what is considered "essential," but the general feeling in both hospitals is that it is not productive to petition a court for permission to medicate until there has been actual physical assault or self-injury. In many units this is interpreted to mean that if patients refuse medication (and they must be informed of that right), staff must wait until someone has been hurt before seeking court permission to administer medication. As with issues about R/S, such attitudes are now unaminous." (p. 41)

The study describes why "security cannot be easily viewed independently of treatment in a treatment setting where physical control is necessary" (p.2). Since security and patient safety are primarily provided by direct care staff, the level of staffing directly affects the adequacy of security.

> "Overall, for both hospitals (the DMH hospital system), it is projected that to provide safety and treatment the average increase in staffing should be 2.6 ward level positions per ward."

The study reports that increased demands create a "feeling of impatience concerning inability of staff to do their jobs adequately..."

> "Although this feeling was typically related to complaints about staff shortage, it is important to realize that the many factors increasing daily workload can transform once adequate staffing levels into inadequate levels. We have seen these effects stemming from the numerical increase of admissions, the increasing concentration if not actual number of violent patients in the population, the increasing requirements for documentation of treatment needs, treatment plans, actual interventions, and treatment outcome. The increased arena of patients rights requiring more laborious procedures in assuring the observation of rights, more workload in attempts to treat patients who refuse medication and much more preparation for the increased number of court appearances related to increasing proportions of involuntary patients and readier access to court challenge embodied in patients rights legislation. While

these factors and more have been involved in increasing staff workload, because the number of patients present (the average daily attendance 'ADA') has shown relatively little change, no increase in the number of funded positions has matched the increase in actual workload, staffing that might have been adequate ten years ago is no longer sufficient."

TASK FORCE RECOMMENDATIONS

The task force made no recommendations related to this issue.

SPECIAL PROGRAM TO HOLD AND TREAT THE DANGEROUS MENTALLY ILL

As discussed, there are many problems associated with the care and treatment of the dangerous mentally ill. There is the question of what system should have primary responsibility for them, the criminal justice or the mental health system. Criminal justice personnel are not trained to deal with mental health problems and mental health practitioners are generally not trained to deal with violent behavior. The dangerous mentally ill are generally very difficult to treat and sometimes are untreatable. They require a significant expenditure of resources even though their numbers are relatively small. For some practitioners this is difficult to justify in times of limited resources which must be taken from other clients who are more responsive to treatment.

Survey respondents were asked if a special program is needed for holding and/or treating the dangerous mentally ill. The results are shown in the following table.

TABLE 26

A SPECIAL PROGRAM SHOULD BE DEVELOPED FOR HOLDING AND/OR TREATING THE DANGEROUS MENTALLY ILL PERSON

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	42	89.4%	65	89.0%	26	83.9%	133	88.0%
Disagree	5	10.6	8	11.0	5	16.1	18	12.0
	47		73		31		151	

Those who agreed were asked to describe the kind of program they felt was needed. The responses were categorized as shown below. Most respondents answered in more than one of the categories.

36.8% - Intermediate care facility

34.8 - Locked setting staffed with treatment and security people -- an isolated self-contained unit

33.7 - Expansion or modification of existing system

27.0 - Separate hospital facility with good diagnostic service to determine placement

21.7 - Maximum security treatment unit

15.9 - Community Mental Health forensic division

14.5 - Community psychiatric ward

9.6 - CMHC Clearinghouse for information exchange -- holding DMIP

6.1 - Forensic treatment program for DMIP in community with emergency psychiatric care available at the State Hospital

Several survey respondents felt that some dangerous mentally ill persons are untreatable and that these people should be housed in secure facilities with humane conditions, but that they should not be released and valuable resources should not be expended for the ineffective treatment.

SURVEY RESPONDENT RECOMMENDATIONS

- Forensic services should be more available to all areas of the state.
- The Denver area needs one central coordinating point to deal with DMIPs. It should look at all aspects and be comprehensive in its frame of reference.
- Fort Logan should have "halfway" facilities for uncertifiable clients who need long term care.

TASK FORCE RECOMMENDATIONS

- A FORENSIC OBSERVATION UNIT SHOULD BE ESTABLISHED IN THE METRO AREA.
- MENTAL HEALTH SERVICES IN THE DEPARTMENT OF CORRECTIONS SHOULD BE EXPANDED.
- A MULTI-SECURITY DOMICILIARY UNIT FOR LONG TERM VIOLENT PEOPLE WHO ARE INCAPABLE OF SURVIVING IN AN UNSUPERVISED SETTING WITHOUT ENDANGERING OTHERS SHOULD BE BUILT.

RELEASE AND FOLLOWUP

Several issues related to release and followup have been identified by the survey and other studies to include:

Assessing when a person is no longer dangerous

Who should make the release decision?

Followup care

Each of these issues will be discussed in the following pages.

ASSESSING DANGEROUSNESS FOR RELEASE DECISIONS

Assessing dangerousness and some of the difficulties associated with it were discussed in the entry section of the report. Another assessment (or a continuous process of assessing dangerousness) must be completed in order to make the decision to release the patient back into the community. The assessment which is made at entry is usually based on recent events and is more of a process of identification. At the point of release, the decision takes into account the person's history of violence, but must also weigh the effect of treatment and predict whether or not the person will be dangerous in the future.

Many factors are taken into account in making the release decision, some objective and many subjective. However, there are no uniformly accepted indicators of dangerousness which can be used by clinicians.

Survey respondents in the mental health system were asked to rank a set of factors reported by Monahan (1981) to be important in clinical determinations that a dangerous patient is ready for release. The results are shown in Table 27 on the following page.

The table shows that the client's ability to articulate resolution of stress producing situations was the highest rated factor considered. The duration of institutional treatment was the lowest rated factor. The top rated factors generally focus on the individual's behavior and psychological state of mind. The lower rated factors focus on institutional rated factors such as maximum institutional benefit or duration of treatment.

In the State Hospital Security Study, Wilson, Rose and Ellis describe how clinical evaluations of risk are determined. The clinical evaluation usually includes knowledge of the following:

- the patient's recent and distant history of violence, if any,
- any threats the patient has made recently,

TABLE 27

IMPORTANT FACTORS IN DETERMINING WHEN A PERSON IS NO LONGER DANGEROUS TO OTHERS

Factors	Rating					$\bar{x}$	Rank
	Best 1	2	3	4	Worst 5		
Development of Ability to Articulate Resolution of Stress Producing Situations	13 (29.5)	17 (38.6)	11 (25.0)	2 (4.5)	1 (2.3)	2.114	1
Acceptance of Guilt and Personal Responsibility for Offense	12 (28.6)	13 (31.0)	10 (23.8)	6 (14.3)	1 (2.4)	2.310	2
Behavior During Hospitalization or Treatment	10 (23.8)	13 (31.0)	13 (31.0)	5 (11.9)	1 (2.4)	2.381	3
Fantasies of Violent Behavior	12 (30.0)	11 (27.5)	10 (25.0)	3 (7.5)	3 (7.5)	2.500	4
Seriousness of Anticipated Conduct	5 (14.3)	13 (37.1)	10 (28.6)	5 (14.3)	2 (5.7)	2.600	5
Change in Community Circumstances	2 (5.0)	15 (37.5)	14 (35.0)	6 (15.0)	3 (7.5)	2.825	6
Achievement of Maximum Benefit from Hospitilization or Treatment	6 (15.4)	7 (17.9)	9 (23.1)	6 (15.4)	11 (28.2)	3.231	7
Duration of Institutionalization or Treatment	1 (2.6)	8 (21.1)	7 (18.4)	15 (39.5)	7 (18.4)	3.500	8

N = 40 # = Frequency ( ) = Percentage

- the current level of control, hostility, anxiety and depression shown by the patient,
- recent changes in the patient's life situation,
- whether these changes are affecting the patient in a positive or negative manner,
- the patterns of previous acting out or threatening,
- whether a gradual progression of reliable warning signs can be expected for this patient and whether those have occurred,
- the kinds of external control measures effective for this patinet,
- the opportunity for dangerous behavior permitted by alternative possible situations,
- situational factors that might enhance the potential for danger for the particular patient.

This list of indicators used in the state hospital contains many of the same indicators rated in the survey as important.

In order to assess what respondents felt about the state hospitals' assessment of dangerousness, respondents were asked to indicate if they were satisfied with both agency's ability to determine when a patient is no longer dangerous. Regarding Colorado State Hospital, 19 (18.8 percent) of the respondents were satisfied with the hospital's ability to determine dangerousness and 78 (81.3 percent) were not satisfied. For Fort Logan, 16 (20 percent) of the respondents were satisfied with the facility's release procedures and 64 (80 percent) were not satisfied. The results by agency type are shown in the following two tables. Mental health practitioners were generally more satisfied than criminal justice practitioners.

TABLE 28

PRACTITIONERS SATISFACTION WITH CSH PROCEDURES FOR DETERMINING WHEN A PATIENT IS NO LONGER DANGEROUS

	Mental Health		Law Enforcement		Judiciary/Attys	
Yes	11	40.7%	3	7.5%	4	13.8%
No	16	59.3	37	92.5	25	86.2
	27		40		29	

TABLE 29

PRACTITIONERS SATISFACTION WITH FORT LOGAN PROCEDURES FOR DETERMINING WHEN A PATIENT IS NO LONGER DANGEROUS

	Mental Health		Law Enforcement		Judiciary/Attys	
Yes	11	39.3%	3	9.1%	2	10.5%
No	17	60.7	30	90.9	17	89.5
	28		33		19	

Most survey respondents (84 percent) felt that the state hospitals should hold dangerous mentally ill persons for a longer period of treatment. Many of the respondents cited cases of people with a long history of mental health and/or criminal justice problems who have been placed in a state hospital, released after a very short period of time, and then have committed another violent act. The following table shows the results of a question regarding longer treatment by type of agency. Although most respondents were dissatisfied, it is interesting to note that rate of satisfaction for mental health and judicial respondents, who have some control over release decisions, was higher and almost identical.

TABLE 30

STATE HOSPITALS SHOULD HOLD DANGEROUS MENTALLY ILL PERSONS FOR A LONGER FERIOD OF TREATMENT

	Mental Health		Law Enforcement		Judiciary Attorneys		Total	
Agree	27	75.0%	53	93.0%	20	76.9%	100	84.0%
Disagree	9	25.0	4	7.0	6	23.1	19	16.0
	36		57		26		119	

Some of the interagency problems related to length of stay and release from the state hospitals result from differences in philosophy, such as the conflict between the duty to protect the public and the need to respect the individual rights of a given patient, and misunderstandings of the statutes, which require that clients have the right to be released when they are assessed as no longer dangerous.

Limited resources within the system may also lead to the premature discharge of some dangerous mentally ill persons, which also contributes to the dissatisfaction with the length of stay.

Survey respondents were asked if their agency ever discharged a dangerous mentally ill person because of failure to find a long term state hospital placement. 20.5 percent of the respondents said their agency had. Respondents were also asked if there are any unofficial reasons why mentally ill persons are released from their facility. The following reasons were ranked at least a three on a scale of one as most important and five as least important.

TABLE 31

UNOFFICIAL REASONS FOR RELEASE OF MENTALLY ILL PERSONS

	%	N
Need for bed space	28.1 (9)	(32)
Behavior problems which disrupt normal operations	34.3 (11)	(32)
History of treatment failure	38.2 (13)	(34)
Don't want to use resources to treat "untreatable" cases	16.6 (5)	(30)
Criminal offense not serious enough to prosecure	48.3 (15)	(31)
Mental illness does not meet criteria for certification	76.4 (26)	(34)

The number of practitioners who responded to this question was small. This can be accounted for in two ways. One, many respondents are not involved in release decisions; and second, several respondents objected to the question. As Miller reported, treatment personnel maintain that dangerous patients are not released until the patient is ready, and as Miller also noted, "when the patient is ready" is defined in the context of pressure for new admissions. This again raises the issue of dangerousness assessment and release and followup procedures.

As discussed earlier, respondents felt their own assessments were accurate. There are several plausible explanations in the disparity between perceptions of accuracy of indicators used by self and others.

Subjective Bias: It is normal to think your own method is better. As wilson, Rose and Ellis (1981:12) reported, "... each clinician depends very heavily upon his/her own clinical intuition."

Other Pressures are Operating Which Affect Assessments of Dangerousness: Overcrowding which requires an assessment of relative dangerousness; a practitioners belief that this may be the only means of providing needed treatment; belief that the patient will refuse treatment.

Different Timeframes: One can be more confident of short term predictions.

Predicting to Different Situations: Police see people in the community and predict they are imminently dangerous in the community; treatment personnel use behavior observed in a treatment setting to predict behavior in the community.

SUPVEY RESPONDENT RECOMMENDATIONS

- Colorado State Hospital should set up an independent group for evaluations and release decisions.

TASK FORCE RECOMMENDATIONS

No specific recommendations were made related to this issue.

WHO SHOULD MAKE THE RELEASE DECISION?

As discussed above, there is some disagreement regarding the release of patients who were admitted as dangerous mentally ill. There is also some disagreement between mental health and criminal justice system practitioners regarding who should make the release decision. Several questions asked on the survey related to this issue.

As shown in the following table, most respondents felt that the courts should be more involved in the discharge of a dangerous mentally ill person who was civilly committed.

TABLE 32

COURTS SHOULD BE MORE INVOLVED IN THE DISCHARGE OF A DANGEROUS MENTALLY ILL PERSON WHO WAS CIVILLY COMMITTED

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	23	56.1%	32	57.1%	25	83.3%	80	63.0%
Disagree	18	43.9	24	42.9	5	16.7	47	37.0
	41		56		30		127	

Respondents were also asked about court and district attorney involvement in the release of criminally committed dangerous mentally ill. The results are presented in the following two tables.

TABLE 33

THE COURT SHOULD BE LESS INVOLVED IN THE DISCHARGE OF A DANGEROUS MENTALLY ILL PERSON WHO WAS CRIMINALLY COMMITTED

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	6	13.3%	16	22.9%	3	8.6%	25	16.7%
Disagree	39	86.7	54	77.1	32	91.6	125	83.3
	45		70		35		150	

TABLE 34

THE DISTRICT ATTORNEY SHOULD BE MORE INVOLVED IN THE DISCHARGE PROCESS FOR DANGEROUS MENTALLY ILL PERSONS

	Mental Health		Law Enforcement		Judiciary		Total	
Agree	10	35.7%	42	77.8%	15	53.6%	67	60.9%
Disagree	18	64.3	12	22.2	13	46.4	43	39.1
	28		54		28		110	

Many respondents felt that the release decision for the dangerous mentally ill should be made by the court and mental health. According to Table 36, 41.9 percent of the 143 respondents thought the court and mental health should make the release decision for criminally committed persons. This was the most common response. Other respondents were equally divided between placing the decision with the courts (25.9 percent) or mental health professionals (21.7 percent). Mental health professionals are more likely, as might be expected, to place the responsibility on solely mental health practitioners than representatives of the criminal justice system.

A related question is when should civilly committed persons be released to the community from the state hospitals. Most of the respondents suggested that they be released after the case has been reviewed and assessed. These respondents then offered recommendations as to who should be involved in civil commitment releases. The results of their thoughts are presented in Table

In total, 15.7 percent thought that when the court approved of the release it was appropriate, 49.4 percent thought mental health approval was sufficient, 27.7 percent thought both mental health and the courts should be involved in the release decision, 3.6 percent thought the district attorney's office should also have input, and some (3.6 percent) suggested the court and treatment facility should make the decision. The table reveals a tendency for criminal justice respondents to place more emphasis on relying solely on the courts, and mental health on the mental health system.

Several other problems related to recommendations and input on the release decision from various agencies were identified by survey respondents. Release procedures for forensic commitments require notification of the court and district attorney when the patient is diagnosed as no longer dangerous. If there are no objections, release procedures may proceed. The district attorney, however, may contest the decision. In contested cases, the DA has the burden of proof in bringing a preponderance of evidence that the patient is still dangerous. Several district attorneys expressed frustration at the difficulty in case preparation caused by the concept of "preponderance of evidence." There is no objective means of knowing when this point (of preponderance) is reached.

The defendant or his attorney may request a release hearing. If the chief officer of the institution contests the release, the burden of proof is on the defendant to provide a preponderance of evidence that he is no longer dangerous. Judicial, district attorney, county attorney and public defender respondents reported that conflicting testimony of mental health professionals creates a

TABLE 35

WHO SHOULD BE INVOLVED IN THE RELEASE OF CIVILLY COMMITTED PERSONS FROM STATE HOSPITALS

	Court	Mental Health Professional	Court/ Mental Health	Court/ Mental Health/ District Attorney	Court/ Treatment Facility
Mental Health System	2 (9.5)	13 (61.9)	5 (23.8)	0	1 (4.8)
Criminal Justice System	11 (17.8)	28 (45.2)	18 (29.0)	3 (4.8)	2 (3.2)
Total	13 (15.7)	41 (49.4)	23 (27.7)	3 (3.6)	3 (3.6)

= Frequency

( ) = Percentage

TABLE 36

WHO SHOULD MAKE THE DECISION TO RELEASE CRIMINALLY COMMITTED DANGEROUS PERSONS FROM CSH

	Court	Mental Health Professional	Court/ Mental Health	Court/ Mental Health/ District Attorney	Court/ Treatment Facility	Court/ District Attorney	DOC/ Treatment Facility
Mental Health System	7 (19.4)	15 (41.7)	12 (33.3)	0	2 (5.6)	0	0
Criminal Justice System	30 (28.0)	16 (14.9)	48 (44.8)	8 (7.5)	3 (2.8)	1 (1.0)	1 (1.0)
Total	37 (25.9)	31 (21.7)	60 (41.9)	8 (5.6)	5 (3.5)	1 (0.7)	1 (0.7)

= Frequency

( ) - Percentage

credibility problem in release hearings. With no consensus of opinion among the mental health professionals, the court must rely on other information in tendering a decision. Another similar problem is the reluctance of mental health treatment personnel to testify. According to the respondents, these treatment personnel are either afraid of revenge or have become sympathetic to the defendant through daily contact in the treatment setting.

If a hearing results in an order for release, or if the institution or district attorney does not contest the release, the patient can no longer be legally held. Although CSH reports that this is not usually a problem, there have been cases where the defendant has demanded immediate release. In these cases, there is not sufficient time to plan for the followup of the patient.

TASK FORCE RECOMMENDATIONS

No recommendation was made regarding this issue.

FOLLOWUP CARE

> "It is the responsibility of the mental health service delivery system to assure that persons discharged from inpatient care will receive planned, adequate, appropriate followup care which will prevent or minimize the need for further inpatient care and promote the best possible social adjustment. Responsibility for followup care generally rests with the catchment area mental health center. However, in specific cases, followup care may be provided by CSH or FLMHC if the responsible center and the hospital agree that such is in the best interest of the client." This quote is taken from the State Mental Health Plan prepared by the Division of Mental Health.

According to Division of Mental Health policies the planning for release and followup care begins at the time of admission to inpatient care or during the preadmission process. It is a joint process between the community mental health center and hospital staff. The client is involved in the process to maximum extent possible. When the client is released the need for followup care is assessed and the client may be discharged with no further followup assigned or may be released with a plan for continuing care in the community.

Survey respondents were asked how satisfied they were with the state hospitals' followup procedures. Over half of the respondents indicated that they were not satisfied with the procedures. The responses by agency type are shown in the following table. Mental health respondents were more satisfied than either the judiciary or law enforcement. However, 46 percent of the mental health respondents indicated dissatisfaction with the procedures.

TABLE 37

HOW SATISFIED ARE YOU WITH
THE STATE HOSPITALS' FOLLOWUP PROCEDURES

	Mental Health		Law Enforcement		Judiciary		Total	
Very Satisfied 1	6	16.2%					6	6.7%
2	8	21.6	2	5.1	1	4.3	11	11.1
3	6	16.2	13	33.3	10	43.5	29	29.3
4	11	29.7	15	38.5	9	39.1	35	35.4
Very Dissatisfied 5	6	16.2	9	23.1	3	13.0	18	18.2
	37		39		23		99	

Several respondents from mental health centers indicated that patients have been released from the state hospitals without their knowledge. Similarly, a patient may be released into a catchment area and become the responsibility of a center which did not refer the client and has never worked with the client before.

The State Auditors reviewed the continuity of care procedures in the mental health systems during their performance audit of the Department of Institutions, completed July 1981. They found several problems related to compliance with the Division's and hospitals' policies and procedures designed to ensure continuity of care for discharged patients, monitoring of community mental health centers' policies and procedures, information flow between the hospitals and centers, and release of patient information. Discharge summaries were often prepared late and at CSH, 62 percent of the discharge summaries contained no recommendations concerning what ongoing treatment is appropriate. There was an over-reliance on verbal and telephone contact between the hospital and the "receiving agency."

The auditors made the following recommendations regarding continuity of care, all of which have been or are being implemented by the Division of Mental Health. These changes address some of the coordination and information exchange issues identified in the survey.

- Both hospitals should cease to rely on verbal and telephone communication for discharge planning and transfer of patient information and should back these methods up with the more reliable method of timely, written communication for the transfer of vital patient information.

  This was implemented at Fort Logan on February 25, 1981 and will be implemented at CSH by September 1, 1981.

- Both hospitals should establish a regular procedure for reviewing discharged patients' charts for compliance with hospital policies concerning discharge planning, discharge referral and discharge summary content and timeliness.

  This was implemented at Fort Logan on July 1, 1981 and will be implemented at CSH by September 1, 1981.

- Colorado State Hospital should adopt a procedure similar to that of Fort Logan Mental Health Center for the completion of a Discharge Referral at the time of discharge.

  This has been accomplished as part of the revision of the referral procedure at CSH. Discharge referral shall be accomplished at the time of discharge.

- The Division should regularly review all continuity of care written policies at community mental health centers and clinics and designated facilities. They should further undertake an evaluation of the extent to which such written policies are followed.

  The Division will conduct a detailed review of the Continuity of Care policies of each center and clinic within the next three months.

Persons who are involuntarily civilly committed as dangerous as a result of mental illness must be released when they are no longer dangerous. As discussed earlier, they can either be discharged with no followup care required or they can be released with a treatment plan which outlines continuing care. Upon release the patient may choose to follow or not follow that plan.

One complaint of survey respondents, especially law enforcement, concerns follow through on medication and treatment after release. A dangerous person may be referred to the mental health system and his violent actions can be and are controlled in a hospital setting. Once released, he refuses further treatment, does not continue medications and once again becomes violent.

The mental health system has no way to force compliance with the treatment plan or to revoke release if it is not followed. If the person becomes dangerous, the commitment process must be started again.

Persons who are criminally committed, on the other hand, must be released by the court and CRS 16-8-115 (3) allows the court to "impose such terms and conditions as the court determines are in the best interest of the defendant and the community." According to survey respondents, often there is not adequate followup and enforcement of conditions of release.

Senate Bill No. 1 "Concerning Conditional Release From Confinement After a Verdict of Not Guilty by Reason of Insanity" outlines the procedures to be followed for the enforcement of conditions and revocation of conditional release from commitment if the conditions are not followed. The bill defines responsibilities of various people in the criminal justice and mental health systems. The bill also provides for the transfer of information between the two systems. CRS 16-8-115 (3) is amended to read "(e) As long as the defendant is granted conditional release and is subject to the provisions thereof, there shall be free transmission of all information, including clinical information regarding the defendant, among the Department of Institutions, the appropriate community mental health centers, and appropriate district attorneys, law enforcement and court personnel."

The implementation of this bill which became effective July 1, 1981 should resolve some of the problems associated with the conditions of release for those found not guilty by reason of insanity.

SURVEY RESPONDENT RECOMMENDATIONS

- The state hospitals should provide halfway houses for releases on an ongoing basis.

TASK FORCE RECOMMENDATIONS

- FOLLOWUP AND CONTINUATION OF CARE SERVICES SHOULD BE EXPANDED.
  - DANGEROUS MENTALLY ILL PERSONS SHOULD BE PROVIDED FOLLOWUP AND CONTINUATION OF CARE SERVICES ON A NON-CATCHMENT AREA BASIS.
  - THERE SHOULD BE DECENTRALIZED SHELTERED WORKSHOPS.
  - THERE SHOULD BE INCREASED FUNDING TO LOCAL MENTAL HEALTH CENTERS FOR CONTINUATION OF CARE FOR NON-DANGEROUS CRIMINAL JUSTICE CLIENTS.

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APPENDIX A

APPENDIX A

METHODS

The purpose of this study was to collect and analyze information on the following issues:

- Is a more integrated data system with unified procedures and practices for facilitating information exchange and addressing common problems needed?
- What conditions are necessary for a dangerous person to be civilly committed and held, and for how long?
- What kind of and amount of security and treatment is necessary and legal to control the dangerous civilly committed patients?
- At what point in a criminal commitment to the mental health system or a civil commitment for dangerousness to others should a patient be released?
- What should be done with a dangerous and mentally ill person who appears to be untreatable?
- What procedures are needed for release and followup of dangerous mentally ill persons?

To address these issues and other research questions, the Division surveyed a sample of agencies involved in identifying, detaining, admitting or committing, treating, releasing and following up the mentally ill dangerous or potentially dangerous person; and established a task force to analyze the issues and make policy recommendations to the Department of Institutions.

THE STUDY

For purposes of this study, the dangerous mentally ill person was defined as follows:

Dangerous Mentally Ill Person (DMIP) - any individual who is suspected of being or has been diagnosed as mentally ill, and who has either been arrested for allegedly committing or attempting to commit a crime against a person or has been hospitalized for allegedly committing such an act even though the act was not formally defined as a criminal offense by a law enforcement agency. Crimes against persons include homicide, sexual assault, assault, robbery, kidnapping, and arson.

Three types of data were sought on this population:

Information provided by agencies included in the sample, such as reports and copies of procedures and organizational structure, were collected when interviewers conducted the survey. The documents were used to describe

the organization and characteristics of Colorado's mental health system.

Agency level information was collected, where available, on the number and type of clients (mentally ill dangerous persons) processed by each agency. Data elements asked for were type of intake (emergency, mental health hold, arrest, etc.) and type of disposition (release, commitment, NGRI, incompetent, evaluation, etc.). We also asked for information on training programs, law suits and assaults on staff. Only four agencies were able to provide a part of this information.

Interviews with agency representatives were conducted in order to describe relationships between agencies, problems, procedures and practices.

A purposive sample of criminal justice and mental health practitioners from 11 catchment areas throughout the state were interviewed. The catchment areas surveyed were:

Adams County Mental Health Center
Arapahoe Mental Health Center
Aurora Mental Health Center
Mental Health Center of Boulder County
Centennial Mental Health Center
Colorado West Regional Mental Health Center
Denver Health and Hospitals Mental Health Program
Jefferson County Mental Health Center
Larimer County Mental Health Center
Park East Comprehensive Community Mental Health Center
Spanish Peaks Mental Health Center

Table 1 indicates the variety of agencies whose staff members were interviewed in the course of the DCJ survey. The number of respondents from each agency type is also shown to assist the reader in judging the scope of the survey.

TABLE 1

AGENCY TYPES AND NUMBERS OF RESPONDENTS

Agency	Number of Respondents
Colorado State Hospital	7
Fort Logan	3
Mental Health Centers	22
Emergency Rooms	5
Psychiatric Wards	7
Judiciary	16
Public Defenders	9
District Attorneys	11
County Attorneys	3
Probation	10
Police Departments	37
Sheriff's Departments	8
Jails	13
Community Corrections	2
Parole	7
Other	3
TOTAL	163

Design of the research instrument was based on information from past research, interviews with mental health and criminal justice practitioners, and meetings with staff from the Division of Mental Health. The questionnaire included close-ended and scaled-response questions to measure attitudes, and open-ended questions to allow exploration and discussion of the issues.

Computer analysis was done at the Colorado Bureau of Investigation using the Statistical Package for the Social Sciences. Simple descriptive statistics (frequencies, percentages, measures of central tendency, crosstabs, and correlations) were used in the analysis. In some instances, categories were collapsed to facilitate comparison of attitudes by agency type. Categories were combined as follows:

Attitudes		Agencies	
Strongly Agree Agree	Agree	Mental Health Center Emergency Room Psychiatric Ward Ft. Logan Mental Health Center Colorado State Hospital Private Psychiatrist	Mental Health
Disagree Strongly Disagree	Disagree	Police Department Sheriff Jail Community Corrections Probation Parole	Law Enforcement
		Judiciary Public Defender District Attorney County Attorney	Judiciary/ Attorneys

APPENDIX B

APPENDIX B MINUTES

TASK FORCE MEETING
on the
DANGEROUS MENTALLY ILL PERSON

June 26, 1981
Denver Police Department Auditorium
1331 Cherokee Street, Denver

The Task Force on the Dangerous Mentally Ill Person (DMIP) meeting was called to order at 9:40 a.m. on June 26, 1981 at the Denver Police Department Auditorium, with the following attendance:

	PRESENT	ABSENT
A.M.	Patrick Ahlstrom	Donald Abram
	Steven Block	Thomas Gilmore
	Tarquin Bromley	James Joy
	Richard Castro	Gregory Long
	Herman Diesenhaus	Leo Lucero
	Robert Glover	Betty Neale
	Laurence Greenwood	Yuolon Savage
	Dennis Kleinsasser	John Tagert
	Doris Kyle	Nancy Terrill
	Raymond Leidig	Dan Tihonovich
	Dennis Pierson for Haydee Cort	Guy Till
	Murray Richtel	Ruben Valdez
	Ambrose Rodriguez	Ed Vandertook
	Donald P. Smith, Jr.	Gregory Walta
	S.Z. Sundell	
	Frank Traylor	
P.M.	Patrick Ahlstrom	
	Steven Block	
	Tarquin Bromley	
	Herman Diesenhaus	
	Laurence Greenwood	
	Dennis Kleinsasser	
	Doris Kyle	
	Raymond Leidig	
	Dennis Pierson for Haydee Cort	
	Murray Richtel	
	Ambrose Rodriguez	
	Donald P. Smith, Jr.	
	S.Z. Sundell	
	Frank Traylor	

Mr. Bill Woodward, Deputy Director, Division of Criminal Justice, opened the meeting by thanking everyone for attending and then introduced Dr. Raymond Leidig, Executive Director of the Department of Institutions. Mr. Woodward also introduced the staff who conducted the DMIP Study at Dr. Leidig's request through the State Council on Criminal Justice: Ms. Patricia Malak, Planning Director, Division of Criminal Justice and Ms. Mary Mande, Project Director for the DMIP Study. Mr. Woodward then introduced the Chair of the Task Force, Dr. Dennis Kleinsasser, Director of the Division of Medical/Mental Health Services for the Department of Corrections.

Dr. Kleinsasser stated that the agenda for the day would involve disseminating information to the Task Force during the morning session and discussion of the issues during the afternoon. He stated that the Task Force would spend an estimated three meetings devoted to discussion of the DMIP. Dr. Kleinsasser reviewed the Task Force Objectives. He said that the Task Force would work toward establishing recommendations for permanent mechanisms for addressing problems that are common to all the systems represented by the Task Force; further issues directed toward public policy in terms of preventative detention, i.e., what are the conditions necessary for an individual to be civilly committed and held, and for how long; what kind and what amount of security is necessary; at what point (whether its a criminal commitment to the mental health system or civil commitment for a DMIP) should a patient be released; and what should be done with a DMIP who appears to be untreatable. These are some of the suggested policy issues to be discussed. During today's meeting the Task Force would be asked to clarify these issues as well as add more issues if appropriate. And finally, the Task Force was being asked to generate recommendations for concrete procedures on admission, on length of stay, security and conditions of commitment, release and followup of the DMIP.

Dr. Kleinsasser turned the meeting over to Dr. Ray Leidig who explained how the study originated.

Dr. Leidig said that in September of 1979 through March of 1980, the visability of this issue was brought about by four events resulting in four homicides. At the same time, there were many other incidents that took place which did not receive as much public recognition as these four events, but were attributed to mentally ill people. A study was conducted last Spring within a very short timeframe by Dr. Sutherland Miller which led to a series of recommendations for research and analysis and for defining the responsibilities of the mental health system, i.e., what is the responsibility of the state hospitals and what is the responsibility of the community mental health system. Several of the recommendations dealt with inter-system problems such as information sharing, accountability, and responsibility of roles in the various elements of the sytem, i.e., mental health, and criminal justice systems. The public policy issue is similar to that seen in corrections or any area where violence will polarize both of the professions and to a lesser extent, the community. The community's primary interest is in being able to live their lives safely and not have the kind of unpredictable violence that has recently taken place in Colorado.

Dr. Leidig asked the Task Force members as they read the study, to keep in mind that the problems and recommendations are based on opinion and perceptions. The purpose is not to determine which system or which element of which system can handle something better than another. There is a tendancy on the part of the mental health system to avoid responsibility. This is based on facts that are not included in the study. There are very few people in the mental health field trained to treat the violent mentally ill. The field of mental health has as much technology in social activism as it has in therapeutics. In the field of mental health there are many standards that veer away from excellence in the field. There are contradictions between the responsibilities that a therapist in the public domain has versus the private, that have never been reconciled. The role of enforcer in the mental health profession is an unwelcome one. But if the public charge is accepted (by accepting public funds) then the therapists are responsible to the public. This is a very serious conflict in the mental health field.

Most training is provided on the job. Education is available, but it is up to individuals to provide it for themselves. It takes very well educated people to detect and treat the violent mentally ill. It takes a different consciousness and awareness on the part of the professional regarding their responsibility in a public system which is quite different than a private practice where the issue does not have to be dealt with unless you desire to do so.

Dr. Leidig said that the Division of Criminal Justice, as a result of his request to the State Council on Criminal Justice began a series of inquiries and dialogues as to the views and opinions of people across the system, i.e., mental health and criminal justice. It is his hope that by becoming aware of the entire system's expertise, procedures and problems, a public policy can be developed, followed by procedures which will make the individual responsible and more accountable to the system, thereby making the system more responsible and more accountable to the public without violating the precious rights of the individuals involved.

Dr. Laurence Greenwood stated tnat he agreed with what Dr. Leidig had said. It was his experience that he too found a lack of skill and experience among mental health workers, at least in the out-patient setting with the violent mentally ill. When encountered with a violent mentally ill case, they are completely unaware of how to handle it.

Herman Diesenhaus stated that the acceptance of public money leads to an acceptance of responsiblity. In the alcohol and drug abuse field where many of the practitioners are paraprofessionals, and use to dealing with the so called "normal" alcohol/drug abuser, it becomes even more difficult. The borderline between these two treatment fields is one of the system interfaces that needs improvement, i.e., how to tell the agencies that are contracted with what their responsibilities are.

Dr. Robert Glover provided an update on new legislation which might impact the work of the Task Force. He said that there were almost 100 bills that had indirect and direct relationships to mental health, and 40 bills that had very direct impact on mental health. There were five bills that were passed that relate specifically to the criminally insane. There has been a shift in attitude in Colorado, toward the protection of society. Of the 40 bills there was not one bill that addressed patients' rights in terms of protection of those rights. All decisionmakers should have an awareness of patients' rights, he said.

Dr. Glover also stated that as far as resources are concerned, the mental health system has been mandated to open up a forensic unit in Pueblo, expand the maximum-medium security potential, close down some of the programs that involve the violent mentally ill, and open a 24-bed facility at Fort Logan for the violent patient. The resources that went to the Department of Institutions were earmarked specifically for the violent mentally ill.

At this point, Dr. Glover gave a review of legislation impacting upon the issues being discussed. The five bills that passed are:

1. Senate Bill 1: Concerning Conditional Release From Confinement After A Verdict Of Not Guilty By Reason Of Insanity (Senator Ezzard)

   Status: Signed by Governor Lammon June 12, 1981.

   Summary: Establishes procedures to revoke conditional releases of NGRI patients when the defendant has violated one or more conditions of the release.
   Impact: In general, S.B. 1 appears to be an improvement compared to the current procedure. The current procedure is inferentially based upon a State Supreme Court decision dating to about 1975. There are no clearly defined procedures being used statewide, and there seems to be variation even within judicial districts. This law will clarify the situation regarding revocation of conditional releases, and will lend statutory credence to the revocation of conditional releases.

   The Division of Mental Health supported the bill as amended, and was in agreement with the revisions which removed the requirement that a person be automatically taken to a 72-hour treatment and evaluation facility. The revisions provided that a person would be taken to one of the state hospitals or a jail, based upon what is determined to be appropriate. The final bill allows for revoking conditional releases when the condition has been violated and the person is considered to be dangerous.

   A potential problem with the law will be the difficulties involved in tracking patients, especially those who are out of contact with mental health providers.

2. Senate Bill 100: Concerning The Confidentiality Of Information And Records Regarding Mentally Ill Persons (Senator Zakhem).

   Status: Signed by Governor Lamm on May 18, 1981.

   Summary: Provides that information concerning a criminal offense committed in an institution providing mental health treatment or against staff shall not be privileged or confidential.

   Impact: The Division of Mental Health opposed S.B. 100 as introduced; however, amendments were adopted which ensured the protection of patients' rights. Although this had been the primary concern of DMH, it had been addressed by the amendments.

3. House Bill 1021: Concerning Procedures In The Criminal Insanity Statutes (Representative Spelts).

   Status: Signed by Governor Lamm on April 30, 1981.

   Summary: Provides that, unless the court permits, for good cause shown, a defendant is not entitled to a release hearing for at least one year subsequent to the initial release hearing.

   Impact: The advantage to this law is that it should reduce the number of inappropriate release hearings and should save staff time in hearings at both state hospitals.

4. House Bill 1060: Concerning Release Hearings For Criminal Defendants Found Not Guilty By Reason Of Insanity (Representative Johnson).

   Status: Signed by Governor Lamm on May 13, 1981.

   Summary: Authorizes the court to deny a request for a release hearing made by a criminal defendant committed after being found not guilty be reason of insanity, when none of the release examination reports indicates the defendant is eligible for release.

   Impact: This legislation seems to streamline the procedures for conditional release in that it does not require a court hearing when none of the release examination reports (prepared by the staff of the Forensic Unit at CSH) indicates the defendant is eligible for release. This should reduce the amount of time staff spend in court hearings, when the hearings are not necessary.

5. House Bill 1281: Concerning Procedures When A Criminal Defendant Is Determined To Be Incompetent (Representative Skaggs).

   Status: Signed by Governor Lamm on June 12, 1981.

   Summary: Allows certain community treatment options for persons judged incompetent to proceed.

   Impact: The primary impact would seem to be beneficial, as it would allow defendants to be examined and/or treated in facilities other than mental health institutions with security capabilities. There are cases when mental health treatment of the incompetent to proceed could be carried out in non-secure hospital or outpatient settings. There is the possibility, however, that the number of incompetent to proceed pleadings and findings would increase and the cost of services could increase.

   This legislation also eliminates a potential constitutional problem by requiring a review of incompetency every six months and terminating criminal proceedings if it is determined that the defendant will not be restored to competency.

Dr. Glover Stated that it is too early to tell what impact these five bills will have on the mental health system but he will report to the Task Force members in approximately three to six months the noted impact.

A discussion followed involving the shift away from patients' rights to concern for public safety; and the lack of funding available which creates more problems, such as not being able to provide secure settings and having to chain patients to beds. Dr. Glover stated that the Task Force members need to acknowledge that chaining patients to beds does happen, and take a stand against this type of inhumane treatment. The renovation being done at this time will bring Pueblo to the point where they will only be able to take care of the existing population. It is very frustrating, he said, to not be able to provide the services needed.

Judge Richtel stated that even though he is not a psychiatrist, he has heard enough testimony to lead him to believe that there are some people who cannot be treated. He said this should be recognized and a balance struck between the interest of society and the interest of those individuals and do something about it. If it means going back to some kind of "warehousing" then that is what is needed, because the shortcomings of the abilities to treat have to be admitted. Perhaps the language in the statutes should be "except for people who are not treatable". He said he hoped he had not shocked anyone, but this was his perspective.

Dr. Greenwood stated that anyone can be treated. The question arose as to whether or not they could be improved. He said he is optimistic about some degree of improvement in some people. He felt that the concern stated is a valid one; punishment may be a form of treatment for some individuals, but for many others, obviously, it is not. The Task Force should direct themselves to respecting the individuality of the mentally ill and be flexible in addressing the problem and trying to keep a full range of treatment and using it appropriately.

Dr. Kleinsasser introduced Mary Mande, the project director of the Dangerous Mentally Ill Person Study, who proceeded to explain to the Task Force members the methodology and results of the study undertaken by the Division of Criminal Justice. The study involved interviews with approximately 200 people throughout the mental health and criminal justice system. (A copy of the study is attached for those Task Force members who were unable to attend the meeting.)

Ms. Mande said the survey was conducted in 11 catchment areas. The sample was taken from law enforcement agencies, courts, and other agencies handling the DMIP from each of those catchment areas. Ms. Mande stated that Dr. Leidig was correct in saying that there is a a great deal of polarization within agencies dealing with the DMIP. A lot of polarization comes about from having to use the concept of dangerousness to make some very important decisions which impact on people's lives. The concept of dangerousness brings together two systems: the criminal justice system which is mandated to provide public safety and the mental health system which seeks to serve the needs of the individual. Violence, or the threat of violence, triggers a chain of events that can lead to the involuntary confinement and treatment of someone that is found to be dangerous to others as a result of mental illness. At first glance, this might seem to be a simple task - to identify someone who is dangerous and mentally ill. A closer look, however, shows that the process

for committing and treating such individuals is very complex. Ms. Mande stated that the staff is currently working on a description of the agencies and the statutory authority that governs them as well as a literature review on dangerousness to others. The results will be distributed to Task Force members upon completion. Ms. Mande said that many of the issues identified in the Division of Criminal Justice study were identified in Dr. Miller's study. The Division of criminal Justice has added the perspective of criminal justice agencies.

Discussion of the findings coincided with Ms. Mande's presentation. Dr. Pierson stated that he believes part of the confusion experienced by all is the lumping of civil commitments and criminal commitments into one group and dealing with release procedures collectively. If they had been separated out there would be fewer contradictions. There are two entirely different sets of statutes dealing with the criminal vs. the civil commitment, leading to a great amount of confusion.

Dr. Sundell stated that one area of confusion lies in using the word <u>prediction</u> of dangerousness vs. looking at the issue as <u>recognition</u> of dangerousness. An example he said, is a person playing Russian Roulette, clearly involved in a dangerous situation that can be recognized. That is very separate from the issue of whether you can predict whether or not he will in fact, kill himself if he pulls the trigger. The legislative or philosophical question is whether we wish to intervene in those sorts of presumptions, i.e., that something can be recognized, and not necessarily predicted. We do this in many areas, he said. The question we really want to come to grips with is whether we want to handle the mental health area the same way we handle other areas even though we may not be able to predict. Based on recognition of certain kinds of dangerousness do we then want to intervene based on that recognition. Ms. Mande suggested that perhaps the Task Force members could accomplish the task of setting criteria which could be used.

Dr. Diesenhaus pointed out that a person under the influence (drug and/or alcohol) is not automatically an alcoholic or drug abuser and therefore, may or may not be the responsibility of the Division of Alcohol and Drug Abuse. Even if they are, there is a very sophisticated diagnostic nuance being used and that is distinguishing between a primary alcoholic and a secondary alcoholic. The alcohol/drug abuse system in Colorado was not built to treat the secondary alcoholic, it was built to treat the primary alcoholic and the differentiation has not been made, leading to confusion.

Dr. Leidig said that the issue of recognition vs. prediction and the differentiation between primary and secondary should not be a police responsibility.

It was expressed by several Task Force members that a lack of knowledge of the laws and lack of information sharing between the systems is a problem.

Mary Mande resumed the presentation of the data in the DMIP study, talking about agency interactions and problem identification. The major problems identified most frequently by those interviewed are:

THE MENTAL HEALTH SYSTEM DOES NOT HAVE SUFFICIENT RESOURCES TO DEAL WITH THE NUMBER OF DANGEROUS MENTALLY ILL PERSONS IN COLORADO AT THIS TIME

and

ORGANIZATIONAL PROBLEMS, SUCH AS CONFLICTING MANDATES AND VALUES, OVERLAPPING RESPONSIBILITIES, FAILURE TO ADHERE TO STATUTES OR ESTABLISHED PROCEDURES; AND APATHY AND INCOMPETENCE OF PRACTITIONERS, REDUCE THE SYSTEM'S ABILITY TO SERVE ITS CLIENTS AND THE PUBLIC EFFECTIVELY.

Ms. Mande continued, stating a number of specific problems relating to the two general problem categories. When specific recommendations were made by those interviewed, the suggested recommendations were also included in the report, beginning on page 25.

Following Ms. Mande's presentation, Dr. Kleinsasser asked the Task Force members to begin thinking about how they should organize themselves to approach the task before them. He also asked the Task Force members if they felt they needed more information before beginning.

Dr. Greenwood said that he felt there are three questions to be answered:

1. What is the best way of taking care of the dangerous mentally ill;

2. What changes need to be implemented in the bureaucracy; and

3. What kind of changes need to be made in the statutes.

It was suggested that once the issues have been organized, small groups could be organized to discuss each issue.

It was decided that the Task Force should read the report in its entirety and meet again on August 7, 1981 and begin then to organize the issues and themselves. Dr. Kleinsasser stated that Division of Criminal Justice staff would have the option to call any of the Task Froce members prior to the meeting on August 7th to discuss any issues that might arise, and the Task Force members should feel free to call the staff as well. The Division of Criminal Justice staff can be reached at 866-3331.

The meeting was adjourned.

TASK FORCE MEETING

on the

DANGEROUS MENTALLY ILL PERSON

August 7, 1981

Denver Police Department Auditorium
1331 Cherokee Street, Denver

The Task Force on the Dangerous Mentally Ill Person (DMIP) meeting was called to order 9:20 a.m., Friday, August 7, 1981 with the following people in attendance:

PRESENT

Donald Abram
Patrick Ahlstrom
Herman Diesenhaus
Irene Cohen
Tom Gilmore
Robert Glover
Laurence Greenwood
James Joy
Dennis Kleinsasser
Doris Kyle
Gregory Long
Harriet Hall for Yuolon Savage
S.Z. Sundell
John Tagert
Guy Till
Murray Richtel
Rita Barreras for Ruben Valdez
Nancy Terrill
Steven Block
Ambrose Rodriguez
John Simonet
Dennis Pearson for Haydee Kort
Sarah Sammons for Tarquin Bromley
Linda Schuman
Tiana Yeager
Ed Vandertook
Betty Neale
Richard Castro
Donald Smith
Greg Walta
Frank Traylor
Leo Lucero
Dan Tihonovich
Ray Leidig

Dr. Kleinsasser began the meeting by asking all members to introduce themselves. He then summarized what had taken place at the Task Force meeting of June 26, 1981 i.e., that the Division of Criminal Justice staff had presented the results of the survey taken and the Task Force members had discussed a variety of information presented. The question at the end of that meeting had been how to structure the Task Force in order to accomplish the task before them. Ideas were presented as to how to divide the task and how to structure the group around those tasks. Since the meeting of June, the staff along with Dr. Kleinsasser created a list of four areas to be discussed and had divided the Task Force into subgroups to discuss each area.

Dr. Kleinsasser stated that prior to the meeting today, several people (Dr. Kleinsasser, Dr. Sundell, Dr. Greenwood and Greg Long) had met and discussed the four topic areas and how best to structure the Task Force. Out of this meeting there arose the feeling that the primary questions to be answered are: who is responsible for the dangerous mentally ill and does the system need a complete overhaul, or only changes to certain areas of the system? Dr. Kleinsasser asked for comments from the Task Force members.

Judge Richtel stated that he felt it was not a good idea to break into smaller groups as it would be more beneficial if the entire group interacted together. He also said that since there appeared to be several areas among the four groups that overlapped, the first two groups should be eliminated, leaving systems entry, systems treatment and systems release to be discussed. He said that he felt the Task Force should concentrate on an ideal, sensible system and determine whether that system would work for Colorado and whether it would involve a major overhaul of the present system.

A variety of opinions were expressed: definitional, statutory and policy issues cannot be handled apart from the specific procedural questions; specific procedural issues cannot be handled without knowing the larger, definitional, statutory and policy issues; how entry is set up within the system, what type of treatment, and who does the treatment, etc., is very dependent upon the larger issues; the ability to develop and refine ideas would be increased by interacting within a smaller subgroup; the Task Force as a whole should discuss the major question and then attack the smaller issues in subgroups, also that definitional, statutory and policy issues could be merged into the three systems areas of entry, treatment and release; and finally, it would be very difficult to separate out the legal issues and then remerge them once having made decisions.

Dr. Greenwood stated that Colorado's multiple systems are destructive in taking care of the dangerous mentally ill. The concern of the Task Force should be public safety and that treatment of the mentally ill is only a tool in the direction of achieving public safety. Public safety is under the jurisdiction of the criminal justice system, it is not under the jurisdiction of the mental health system or the alcohol/drug abuse treatment system as a primary goal. The direction of the Task Force should be to establish care and management of the dangerous mentally ill within the criminal justice system, with hired mental health and alcohol/drug abuse consultants as required to manage the problems.

Dr. Kleinsasser suggested that the Task Force members discuss further clarification of the issue at hand, i.e., the goal of the Task Force. He opened the floor for further discussion.

Dr. Diesenhaus stated that what Dr. Greenwood suggested involved a major policy change for the state requiring legislative, budgetary and institutional change. He stated that he agreed with Dr. Greenwood with the exception of hiring consultants - he felt that a forensic treatment system that ties into the civil system should be built into the criminal justice system.

Judge Richtel said that he didn't understand that position because he deals weekly with mentally ill people that are not criminals (i.e., have not committed any criminal act) and it is wrong to put them into a system where

where the stigma of criminal behavior is attached to them. He felt there should be something similar to an ombudsperson in a particular county who is responsible for entry level decisions. For example, an experienced lawyer can tell whether or not a district attorney is likely to say "this person is evil and we're going to go criminal or "this person is crazy and we're going to go civil" and that decision could be made on the front end instead of having a police officer or a mental health professional make a decision about which system is best for the person. To summarize, he said, he disagrees with having the criminal justice system responsible and he would like to see front-end decisions made.

Greg Long said he didn't feel it was right to put a non-criminal person who may be acting dangerously in with criminals and he didn't feel the legislature would fund the idea. It was his feeling that the mental health system in Colorado feels that if a person is dangerous and difficult to treat, they should be incarcerated and handed over to the criminal justice system. He said the system works well for approximately 90 percent of the people in it, but the subcategory of 10 percent is not handled well because no one knows how to treat them and facilities are not available. The problem of how to handle this type (the 10 percent category) should be looked at rather than dumping them off on a "new" agency or facility.

Irene Cohen stated that she agreed with Judge Richtel in that there should be someone at the front end, on a county level, to make the decision as to which treatment would most benefit the person involved. As long as the question of "what is the ideal system" is not addressed, to include statutory changes, there will continue to be problems with shifting people from one system to another.

Dr. Sundell stated that he disagreed with the premise that the criminal justice system should be responsible because when one looks at the present system what is happening is that forensic patients are being made out of chronic, psychiatrically ill patients. What Judge Richtel was saying requires that there be two adequately functioning systems so that someone can make the decision as to which system a person belong in. The person making the decision would have to have confidence that the appropraite response would be provided by either system. Presently, the criminal justice system does respond - there is a long term, viable disposition for dangerous mentally ill people - after the fact, and that is the forensic division of the Colorado State Hospital. People can be reasonably sure that if someone is criminally committed there, be it incompetency or insanity, that long term treatment will be provided. The inverse is not true. If people are removed from the criminal justice system for some charge, whether it be misdemeanor or felony, and sent into a civil system, the fact is, the way the civil system now functions, is that long term treatment is not provided and what we get is crisis intervention with the person recurring back into the system via another mental health contact or another crime. People push toward forensic dispositions in cases after they have tried the civil system three and four times and often you have someone who is not really a criminal but whose criminal acts continually bring them into the criminal justice system. Finally someone says "all right, we'll go ahead and proceed through the criminal justice system via criminal commitment to the forensic division and this, Dr. Sundell said, is not appropriate. The other manner of people getting into the criminal justice system inappropriately is, again, the forcing of a major criminal act to which the criminal justice system has to respond, after seven or eight attempted civil treatments that do not work becuase of the absence of an appropriate resource. What is needed, he stated, is a mental health system that provides long term civil treatment which does not exist at this time.

Chief Ahlstrom stated that what Dr. Sundell just said is exactly what causes initial frustration for the policemen and the prosecutor - to see a person that one knows, if not helped, is going to be back into the system.

Judge Richtel said that we should admit that we are unable to help 10 percent of the people and start working on a constitutional solution to the problem.

Dr. Diesenhaus stated that there is an interface between mental health and criminal justice that requires specialization to deal with that 10 percent of the people who are deemed untreatable. We need to be able to identify that 10 percent and provide the trained staff and appropriate facilities to handle them.

Greg Long stated that in the rural areas there are a lot of people who are untreatable, but are not receiving the help they require at the time they need help the most, and therefore, end up in the system at a later time.

Dr. Greenwood stated that the authority of the system needs changing so that the criminal justice system has more authority to manage the group of people (the "untreatables") being spoken of. A ground level expansion of facilities is needed so that criminal justice would have a greater degree of authority over these people.

Dr. Pearson said that he felt the issue was much broader than what was being discussed. It is very rare to see adults who have not had extensive histories of juvenile delinquent behavior. The problem is much more basic than whether it is a criminal justice or mental health issue. It is a broad-based social policy issue which requires a solution for example, to the young child who, at age seven is caught stealing and progresses on to a series of minor crimes and as he gets older, the crimes become more serious. The basis that we need to operate from is toward prevention, he said. If a kid is not diverted, he ends up usually as an adult felon.

Guy Till said that another type of patient is the one who does respond to treatment, but only accepts treatment when in a locked setting. The only criminal offense to charge them with is reckless endangerment, when they have gone off their medication and end up hurting someone. A method of controlling this type of person should be available. The person does not necessarily need to be "warehoused", but he does need tracking and he needs to be aware that if he stops taking his medication, he will be brought back into a locked setting. For this type of person, until a crime is committed, he cannot be contained.

Greg Long said one type of solution to this problem is to have supervision authority over the person for a longer period of time (currently, the limitation is two years).

Dr. Diesenhaus said maybe what is needed is a change in the commitment statutes. Dr. Sundell stated that he was not clear as to whether the statutes are adequate or not; it has not been defined as to who is "holdable" and who is not. The present system discourages using the present statutes. It discourages proceeding with one short term commitment after another and discourages filing a long term commitment. The real issue is providing a civil system that has inherent in it, for these 10 percent of the patients, a different system of funding that does not define specific dollars, but provides statewide, long term available inpatient beds that could be used by the state if we want to pursue those civil certifications. The message that we now give as a state is that unless it is after the fact in the forensic division there are essentially no people in our state who really

can be, or should be held for long term, civil, structured treatment - not necessarily locked up in a hospital, but long term, structured followup. The way the state provides facilities at the present time, the message is that these people do not exist. The first issue is to recognize that they do exist and then provide adequate beds, both inpatient, half-way houses, and out-patient continuity of followup within a system that is set up separate from the divisions of the catchment areas in the state, and allow deferrment of the chronic, difficult, expensive, dangerous, repetitive patient to this sytem for continuous monitoring followup and evaluation to the level of treatment needed at any given time, rather than bouncing them back and forth and evaluating them 12 times a year. In order to operationalize this concept, essentially there would be 22 or 27 centers receiving "X" dollars for provision of all kinds of services. Give them "X" minus "Y" dollars for provision of services, outpatient treatment for the 80 percent and crisis inpatient hospital treatment for the acute and semi-acute. The "Y" dollars should be taken back from each of those centers to establish a centralized system for the provision of continuity of care to the difficult - not the dangerous, but the difficult patient, the chronic, the severely impaired patients, and that every center in the state have the ability to refer these people to the centralized system. Once the patient is admitted, he stays there. The centralized system becomes responsible for determining whether that patient needs to be hospitalized or is able to receive out-patient treatment. The responsibility for this would not shift everytime the patient moved, thereby eliminating the necessity for further evaluations of the patient.

Dr. Sundell was asked how the system would work for those people way outside of the "centralized" area. What would happen to a patient in Durango, for instance, who had no desire to be relocated to Denver. Who would provide the entry and followup services for patients in rural areas.

Dr. Sundell said that since the premise that no major felony crime is involved, it would be a mental health issue, so it would be under the Department of Institutions. The hospital beds would have to be centralized for inpatient services. The out-patient treatment roles can be dispersed throughout the stated. It is a single system, it is not bouncing responsibility back and forth.

Judge Abram said that Colorado does not have a system by which a person can be treated in a uniform manner. He works with the Colorado State Hospital and presides over all the mental health hearings for the state, with the exception of the Denver catchment area. He said that once a person is released, even on an out-patient basis, there is no treatment program provided. CSH has no control over the program in other areas. There is no system by which that can be done. The present mental health statutes do not provide a method of forcing a person to be involved in a program. The person is either certified or uncertified. If he is not certified, there is no control. If he is certified and released on an out-patient basis, once the state hospital loses control by referring the patient to a health facility, there is no requirement by court order as to what the person is required to do. The legal system is not responsive to the state's needs.

Dr. Pearson stated that there is a provision where the court can order a disposition of legal disability, but he has never once seen it used in long term treatment.

Dr. Sundell said that Judge Abram presented a very good point in terms of the question "why don't we have people pursuing those kinds of alternatives" and also, how many people in the state are presently certified for long term treatment? Very few, because the system reinforces not doing it. If the beds are provided and the mental health centers are not penalized in terms of dollars for pursuing that sort of disposition, these people would surface. The people are there, but the mental health centers are not pursuing that alternative because it is not in the mental health centers best interests to do so. A new centralized system that does not build in these negative aspects can do something. There would be a lot of people being certified under our present statutes. Then look at the statutes and determine whether they are adequate. Until then, we don't know.

A question was asked about financial arrangements at mental health centers. Dr. Glover responded that mental health centers contract statewide for a variety of services. Part of those services relate to inpatient care. There has been, historically, "sweetheart deals" with some centers whereby they didn't have to purchase inpatient beds - they were given them. Some centers purchase inpatient care from public and private providers within their catchment area and are on a priority list to get patients into Ft. Logan, for example. Nationally, inpatient costs have skyrocketed. The centers have "X" amount of money budgeted at the beginning of the fiscal year for inpatient care. They want to minimize that amount because if they exceed that budget amount, they then have to take it out of other budgeted options including the outpatient budget. The way to do this, when 85 to 90 percent of the money is going to personnel, is to lay off staff in outpatient care to pay for inpatient care. It is, over time, a debilitating issue - costs are increasing and length of stay is increasing. There are presently 132 people on the waiting list for Ft. Logan. As a result, when inpatient beds are needed, you either purchase or go for a less restrictive option that doesn't really meet the needs. A study of the waiting list was done in December (there were 108 at Ft. Logan at that time) and 65 percent of the people on the waiting list were in 24-hour structured settings, i.e,, jails or very expensive ($250 to $350 a day) inpatient care. The centers are very resistive, financially, because the process eats up their budget and forces them to get out of the preventive outpatient care. It shifts to more expensive, more intensive and more restrictive care, which they do not want. Philosophically, the community mental health centers movement was not set up to address the specialized, criminal mentally ill or the violent mentally ill. Most people are not trained to deal with this type of patient. There is a resistance and a feeling that they will end up duplicating law enforcement activities. The centers are also resistive to having to track people. They have not been trained to do it. To some clinicians, it is anti-therapeutic to force treatment.

Dr. Glover stated that protection of society is important, but there is a right to treatment as well, and patients' civil rights cannot be ignored.

Dr. Glover spoke about existing resources and requests for the coming year. There is a new 24 bed, high risk unit centralized at Ft. Logan for the violent patient which will open in October. Planned length of stay is 90 days to six months. In October there will be an increase of 29 beds at CSH in maximum security as a new forensic unit is being added. These are beginning resources to address the problem. For next year, 120 adult community-based, residential beds are being requested through the budget. These will be a transition from the inpatient setting, either at CSH or at Ft. Logan, to an outpatient setting with 24-hour supervision. There is also a request for an additional 18 intermediate security beds. There are now 332 forensic beds at CSH. Approximately 100 beds have been transferred from the intermediate and minimum to medium and maximum security.

Dr. Diesenhaus asked Dr. Glover what outpatient followup unit is being built to handle Ft. Logan bed releases?

Dr. Glover said that the necessity for a forensic coordinator for each mental health center has been defined in their contracts. The coordinator is supposed to deal with the continuity of followup aftercare. A statewide workshop will be presented dealing with the impact of S.B. 1, unconditional release status, etc. The centers do not want increasing responsibilities with decreasing resources. There will be a 25 percent reduction in federal dollars to community mental health centers next year, Dr. Glover stated.

Ambrose Rodriguez said that the mental health centers are required to provide followup services for conditional release patients. He said that another effort being made involves the Continuity Care Committees (at CSH and Ft. Logan) which provides an interface between the hospitals and the centers.

Dr. Glover said that a performance audit by the Legislative Audit Committee had just been completed with the major finding being that there is not enough exchange of information between state facilities and community health centers. There is a bind between patients' rights (the dissemination of patients' records) vs. the continuity of care issue.

Dr. Diesenhaus said he believes what is needed is structural changes as the procedural changes put into place in the past few years appear to not be working. The same people keep reappearing in the system; the chronic repeaters are not getting the help they need.

Greg Long said that one statutory change that could be made is to give judges authority that they now do not have. Give them the authority to say "you will go to the state hospital until you reach this point. When you are eligibile for release under these criteria, you will cooperate with this local mental health center and follow whatever treatment plan the state hospital says is in your best interest. You will follow the treatment plan under penalty of having to go back into a closed facility and the local mental health centers will not be able to refuse the patient simply because he might be a problem to them". In other words, the court has to have the authority and jurisdiction it does not now have. Mr. Long asked Judge Richtel if he could now tell a person that they will follow a specific treatment plan upon release from the state hospital? Judge Richtel replied that they could not - there was no "hold" over them. Mr. Long stated that the courts need that "hold" under the statutes. The judges are not now in a position to tell a local mental health center that they will provide followup treatment, he said. Mr. Long stated that right now, mental health centers will not even exchange information. His local mental health center cannot get followup information from Ft. Logan or Pueblo.

Judge Richtel asked if he meant information sharing was a problem? Ft. Logan cannot give their information to a local mental health center? He directed his question to Dr. Glover. Dr. Glover stated that mental health centers, being private, nonprofit entities are very concerned about being sued. They hesitate to even acknowledge that they have patients in their facilities.

Judge Richtel said that they should confer with their lawyers - it is insanity to be that scared of being sued. He said that you should not be afraid of being sued if you act in good faith.

Dr. Sundell said that is one more reason why community mental health centers are not adequate, because they do have to be afraid of being sued. Insurance companies settle on the face of economics. The doctor loses his reputation. It is as simple as that, he said. The insurance companies do not care whether the doctor is innocent or guilty. They care about whether it is cheaper to settle or to go to court. But the doctor's reputation is ruined either way and medical directors will never be less apprehensive of being sued.

Judge Richtel stated that he had spoken to the Boulder Medical Society recently analyzing statistics in malpractice suits. There is nothing that the system can do to prevent people from being sued. The answer though, is that the system is excellent in terms of results. There has not been a medical malpractice verdict in Boulder for eight years. There have been lots of suits, he said, but to the extent that doctors are doing a decent job, they are winning in those law suits, or they are being settled for peanuts. He said he cannot understand their fear of being sued.

Dr. Pearson stated that as a state agency, they receive different advice from their lawyers than do private mental health centers with private attorneys. they have a certain interest in what can be divulged - the state and the attorney general's office has a different interpretation of the law than private entities. The centers are running scared, he said. Senate Bill 1, which was passed in the last legislative session, mandates that certain information sharing for a NGRI patient will occur, making the job much easier of getting information from the mental health centers when dealing with forensic patients. Already, the mental health centers are hesitating, saying that their lawyers tell them they cannot divulge that kind of information to anyone.

Dr. Sundell said that Judge Richtel is absolutely right, but the issue is that the system is using one reason to cover another. An example, he said, is one he hears all the time - "this patient is not certifiable; I cannot possibly certify him, per the present statutes". What the mental health centers are really saying, he said, is "we don't want to spend the dollars on this person". The judicial issue is used, he said. There are a lot of reasons why information is not shared, but you always hear the fear of being sued because of patient confidentiality. That is not the real issue. We really don't know what the statutes allow, or don't allow, because no one has used them yet because of other reasons that have nothing to do with statutes.

Greg Long said that part of the surface problem could be solved by a modification of the statutues to provide specifically for permission to release information to another treatment agency.

James Joy said that the idea that confidentiality gets in the way is really a red herring. If someone calls him and says that he objects to the fact that the state hospital had shared their files with a community mental health program that was under contract with the state, thus acting in behalf of the state, he would say that they had no case at all. He couldn't guarantee what a private attorney might attempt, but it would not be a case that his office would accept. To the contrary, he said, as long as a patient is not free to walk the streets unhindered by the state, the state has a right to give a patient as good a treatment plan as can possibly be given. If a communications breakdown is interrupting that treatment plan, he felt that the liability goes the other way because of lack of communication.

Guy Till and Judge Abram both stated their opinions that the confidentiality statutes should be changed so that facilities will not be afraid of exchanging information.

Dr. Kleinsasser summarized the discussion by saying that there appeared to be a reasonable consensus among the Task Force members that some kind of specialized program (whether it be centralized or decentralized) is needed to deal with the subgroup of people not being helped by the system as it now exists. Statutory changes are needed also, as well as improved information/communication flow and giving the court system controls they now do not have.

It was also decided that defining the subgroup of people being discussed was yet to be done. Following lunch, Dr. Kleinsasser stated that during the afternoon session concentration would be applied to the task of defining the subgroup discussed during the morning session.

In order to do this, the Task Force would break up into three groups, meet in separate rooms for one hour and then reassemble for further discussion. The items to be discussed would be: 1) definition of the subgroup; 2) what should a new system or program consist of; and 3) who should have oversight authority for the system or program and along with this, statutory changes.

The three groups are as follows:

Group 1: Systems Entry	Group 2: Systems Treatment	Group 3: Systems Release
Greenwood, Chair	Sundell, Chair	Long, Chair
Abrams	Cohen	Yeager
Schuman	Till	Joy
Neale	Lucero	Block
Ahlstrom	Kort	Gilmore
Simonet	Richtel	Kyle
Glover	Savage	Smith
Diesenhaus	Kleinsasser	Traylor
Walta	Bromley	Valdez
Tihonovich	Terrill	

Each group reported their findings as follows:

Group 1 discussed whether to expand facilities or create a new facility. This group discussed changes to the existing system which would provide for continuity of care for dangerous mentally ill clients. A system of case managers to be hired by a state agency would be used to insure that the client received the proper treatment. Group 1 also discussed the resources that would be needed to provide continuity of care.

Group 2 discussed the subgroup population definition. They agreed upon the following:

> "A dangerous mentally ill person is any patient who is dangerous to others or who has an extra ordinary capacity to commit violence. In addition, the following factors (as shown on the following page) shall be taken into account, with no one factor being conclusive nor carrying more weight than any other factor."

Predictors	Indicators
History of Violent Acts:	Violent Ideas
How Frequent	Paranoid Ideas
How Serious	Hallucinations
How Recent	Verbal Threats
Drug or Alcohol Abuse	Bizarre Behavior
Clinician's Judgment	Intense Motor Activity
Stress in Precipitating Situation	
Employment Stability	
Sex	
Socio-Economic Status	
Age	
Race	

Group 3 came to the conclusions that they did not envision any radical changes to the system as it now exists, but legislative emphasis needs to be made clear. Statutory changes and treatment plans should be regulated.

It was stated that different solutions apply for different areas (i.e., Denver vs. rural areas). A need for more statistics was voiced by several Task Force members. It was requested that the staff of the Division of Criminal Justice determine the cost factors involved for a patient who is seen over and over again within the system vs. a patient who spends six months at Ft. Logan. Other statistics asked for included a summary of available resources and how they're presently being used, broken into rural and urban areas and a sample of case histories within the systems.

After further discussion, it was decided that the Task Group would meet again on Tuesday, September 22, 1981 at the Denver Police Department Auditorium. The meeting was adjourned.

TASK FORCE MEETING

on the

DANGEROUS MENTALLY ILL PERSON

September 22, 1981

Denver Police Department Auditorium
1331 Cherokee Street, Denver

The Task Force on the Dangerous Mentally Ill Person (DMIP) meeting was called to order at 9:15 a.m., Tuesday, September 22, 1981 with the following attendance:

PRESENT	ABSENT
Dennis Kleinsasser, Chair	Donald Abram
Patrick Ahlstrom	Steve Block
Irene Cohen	Tarquin Bromley
Herman Diesenhaus	Richard Castro
Robert Glover	Tom Gilmore
Laurence Greenwood	James Joy
Bob Husson (for Ruben Valdez)	Greg Long
Doris Kyle	Leo Lucero
Betty Neale	Murray Richtel
Dennis Pearson	John Simonet
Ambrose Rodriguez	Donald Smith
Youlon Savage	Dan Tihonovich
Linda Schuman	Frank Traylor
S.Z. Sundell	Ed Vandertook
John Tagert	Greg Walta
Nancy Terrill	
Guy Till	
Tiana Yeager	

The Chairman, Dr. Dennis Kleinsasser spoke briefly explaining that a meeting had taken place prior to the meeting today, with DCJ staff, several people from the Department of Institutions and Dr. Kleinsasser. The purpose of that meeting was to determine whether the Task Force was meeting the goals of the original charge given to them and to clarify the objectives. One of the subjects of the meeting was the amount of time spent by members of the Task Force balanced against the impact of the outcome. The consensus of those at the meeting felt that any influence that the Task Force would have would be through whatever activities individual members would take once a final report was issued.

At the last meeting most of the focus was on developing a program for a new structure. Dr. Kleinsasser asked the members to consider alternatives that could be put into effect within the present system (i.e., ways of improving the current system). Dr. Kleinsasser asked Dr. Glover to read the original charge to the Task Force.

Dr. Glover read the original charge from Dr. Ray Leidig, former Executive Director of the Department of Institutions to Richard Dana, Chairman of the State Council on Criminal Justice:

1. To appoint a Task Force consisting of representatives from the Division of Mental Health, the judicial system, the law enforcement system and the Department of Health to begin on or before October 1, 1980 to consider the need for:

   a. a more integrated data system;
   b. more unified procedures and practices;
   c. methods for establishing more mutual understanding of the three systems; and
   d. a permanent mechanism for correcting common problems.

Dr. Glover said that he felt the Task Force had spent a great amount of time to date, and had perhaps delved into too much detail for the level of responsibility shared by Task Force members. He spoke further of the current time frame: the Department of Institutions had submitted their budget request for 1982-83 to the Office of State Planning and Budgeting. The Division of Mental Health and the Department of Institutions had requested an increase of 18 intermediate security level beds at Pueblo for the violent patients. Maximum security beds have increased by 90 beds, but intermediate security beds were lost, resulting in difficulty in moving patients down through lower levels of security. The budget request for community mental health centers and the Division in total has also been submitted. The request was for a 20 percent increase in general funds, omitting any request for new programs. The probability of getting the 20 percent increase is next to zero, he said. The continuation budget for mental health centers for the coming year is $700,000 with a decline in federal funds. The first priority is maintenance of effort before adding any new programs. The mental health centers last year received no dollar increase at all to accommodate inflation resulting in approximately a twelve percent reduction in capacity, statewide.

Dr. Glover stated that he and Ambrose Rodriguez had met with Governor Lamm on Friday, September 18, 1981 to discuss the current status of the violent patient in conjunction with Sutherland Miller's report. The Governor was pleased with certain areas but understands that it is a systemwide issue and problems will not be solved overnight.

Dr. Glover asked the Task Force members to keep their task small enough to be able to accomplish the objectives within a reasonable time frame. He suggested looking at major areas involving possible appropriate legislation.

Dr. Glover asked Tiana Yeager to give the results of a legislative audit which was recently conducted in the Department of Institutions. Ms. Yeager stated that the committee had recommended an amendment to Section 1684-2 of the statutes which currently permits, as a condition of deferred prosecution, a person to be placed in mental health treatment. What has been occurring is that judges have been ordering people to be placed in Ft. Logan for treatment for up to a year and in many cases the person has not needed treatment or when Ft. Logan believes that treatment is completed, the court will not release the patient until the year is up, creating a bottleneck at Ft. Logan. The audit recommended that legislation be modified so that a releasing facility can release the patient back to the court upon completion of treatment.

Dr. Glover stated that if changes to the statutes are to be recommended by the Task Force, the time is now, not three to six months down the road. The Task Force needs to come up with concrete products and given the time frame, he wasn't sure this is possible. He felt that issues the Task Force should address should consist of larger systemwide problems such as information sharing.

Ambrose Rodriguez stated that one thing that had become clear through the meetings of the Task Force was that better dialogue is needed. The Division of Mental Health, as a result, will assign some staff time in an ongoing effort to improve communications between the various systems (i.e., law enforcement, judicial, corrections) and the Division of Mental Health. He anticipates having a fulltime staffperson working in this area.

Dr. Kleinsasser suggested a possible agenda for the day. He said that as a result of the steering committee meeting held immediately following the last Task Force meeting, it was felt that there was a need for better definition of the subgroup (approximately 10 percent of the mental health population) being discussed; and there was a need to look at a variety of cases involving the DMIP. The staff of the Division of Criminal Justice has put together data involving several cases and wished to present the material to the Task Force for their review.

He asked the members of the Task Force to remember that what is required at this point are concrete ideas. He asked that the members come up with specific, prioritized recommendations for improvement of the system by the end of the day. This would be accomplished by breaking up into two small groups which would meet in separate rooms and discuss their ideas followed by a combined group discussion. If this is accomplished at today's meeting, followed by a meeting of Dr. Kleinsasser, Division of Criminal Justice staff and anyone else desiring to submit input, then a draft final report could be generated. This would be followed by one more short meeting of the Task Force members to review the draft final report, with the goal of the Task Force being met. He asked for reactions from the members to this plan.

Guy Till felt that the scope could not be restricted. He stated that the reason there were many people from the criminal justice system attending the Task Force meetings is because so many mental health clients are ending up in jails and in courts. They probably do not belong in jails, but they are not getting the kind of help they need, he said. To put them into jails is frustrating to wardens, it's hard on other prisoners and it creates many problems. From a financial standpoint, people in Denver County are upset because they are spending vast amounts of money (1.8 million dollars per year Mr. Till had heard quoted), on people with mental health problems in the Denver criminal justice system in terms of jail and hospital expenses. Some of the people involved do not have the same kind of interest in public safety as the police department or the district attorneys' office and their theory of action is to just slam the door - get the people out - and Mr. Till wondered where they were supposed to go. He felt that in a couple of years a major problem will occur with these people. He felt that we were on pretty thin ice in handling these people from a legal standpoint and financial incentives to improve the situation are not present.

It was his personal opinion that without changing the economic structure or without changing the definition of 27-10, the system could not be improved. He felt that just trying to make the different parts of the system fit together better would not solve the problems. Budgets are getting very tight; the state does not want to pick up the difference, and the counties do not want to do what they perceive is a state responsibility. Mr. Till said it is a big problem now and will get much worse in a couple of years. The way the district attorneys become involved now is as a result of police officers having learned that by arresting a person rather than taking them to a mental health center, the person will be confined for a length of time and become somewhat stabilized, as opposed to the person often being back on the street before the police officer can fill out his report. From a patients' rights standpoint, this is pretty shaky ground for the criminal justice system.

Chief John Tagert agreed with Mr. Till that the problem will accelerate. In his area there is a significant lack of facilities. They are unable to help people who are voluntarily wanting to be committed, because there is no room for them, he said. Lack of bedspace is a daily problem. There is no room in the jails, he said, as all three counties are in a crisis situation regarding jail space. Jefferson county transports people to Pueblo in order to try and house people on a short term basis. The transportation costs are enormous. Jails are not the answer. He said that in addition to specific recommendations from the Task Force, a very clear message should be sent to the Legislature letting them know that money has to be spent in this area which is not being spent now, or there will be a tremendous crisis.

Dr. Sundell said that the issue of money has come up several times and he is concerned about that, as one of the things discussed at the last meeting was not spending a single extra dollar. He felt that a lot of money for the current system is being wasted and one of the things to look at is how to reorganize the present system to change for the better in order to spend present dollars in a more effective, efficient manner. If we ask for larger sums of money to start new programs, we are not going to get the money and we shouldn't get the money, he said.

Other Task Force members expressed doubt that large transfers of funds from one agency to another is politically feasible - no agency will be willing to give up a part of its budget.

Dr. Greenwood asked Dr. Glover to clarify what the Department of Institutions wanted from the Task Force. He said that he thought he heard Dr. Glover giving a negative request to the Task Force (i.e., don't be expansive, don't look for big solutions, etc.).

Dr. Glover stated that the original charge of the Task Force was for one, possibly two meetings and then for the Task Force members to work individually within the system for improvement. The role definition of the group became much larger than what was expected. Within the Department of Institutions, there is a

five year long range planning committee that is looking at the role of community health centers and state hospitals. It is very important, he said, to consider whether we have the right match of people who have the responsibility and authority to carry out the recommendations of the Task Force. He stated that the Task Force is not currently justified in holding ongoing meetings, unless the original charge is expanded. If we want to take the expansive charge then we have to deal with the problems differently than what he saw as some very gross and fine tuning of the existing system rather than coming up with a brand new model.

Dr. Greenwood asked Dr. Glover if he felt from a personal standpoint that it makes more sense to stick with the original directive.

Dr. Glover stated that he is wondering if we have not made the charge too large to handle by this group given where various entities are, including the Legislature, the Governor's Office and other departmental entities.

Dr. Greenwood asked what good would come if we narrow our focus in conjunction with the original directive.

Dr. Glover said that there are many concrete actions which can be taken. We need changes in procedures, and better communications between the criminal justice and mental health systems. All of the Task Force members could take these kinds of recommendations back to their agencies and implement them, he said. We can work individually and through the various associations to support statute changes which are needed. On a state level, in the long run, we need more resources, he said. We don't have enough beds for the clientel. There are logistics that are being done inappropriately, (i.e., observations at Colorado State Hospital includes 60 percent from the Denver area with 75 percent of psychiatric time from the Denver area) with the result being that costs are considerably higher than if observations were done in the Denver area rather than in Pueblo.

Dr. Sundell areed with Dr. Glover. He said that we <u>are</u> under-resourced at this time, but to talk of more resources at a time when clearly we may not get any more should tell us to look at better use of what we now have.

Mr. Savage said that for the first time since he's been with the mental health system, the community mental health program lost money, in terms of dollars available, coupled with a 12 to 16 percent inflation rate, so the same amount of resources are not available. In addition, there are not enough beds. In the interest of patients' rights we have had to give up controls that society has been able to exercise along with a reduction in not only the use of inpatient facilities, but in a more functional sense, in the number of needed inpatient facilities that are available. The consequence of not having enough inpatient beds is that you can't get some people in when they need it and others are being pushed out before they really should be.

Dr. Diesenhaus questioned the area of the original charge relating to an integrated data system. He asked for specific information as to what is needed. He spoke of practices, and how <u>do</u> you institutionalize better practices? Maybe, he said, that would be a job for a followup group to the Task Force. He said that in his agency he has made some changes already as a result of the Task Force meetings in that he has named Irene Cohen as the criminal justice

and civil commitments specialist. They too, he said, would have one fulltime person who will interface with other systems and try to develop better guidelines for working with this particular type of patient, in both acute and long term treatment situations in the agencies they fund and license.

Dr. Glover asked Dr. Pearson to share an experience he had recently regarding information sharing. Dr. Pearson said that recently a man was sent to the state hospital for an evaluation following a burglary that he had committed. When the state hospital social worker asked for information concerning the patient, particularly the investigative reports, the sheriff's office dutifully complied and sent information concerning the burglary. The patient was not physically restrained and was not in a secure ward. The patient escaped, and following the escape, the state hospital learned that the man had committed a murder while in jail on the burglary charge. The state hospital had been charged to do an evaluation of the person following the burglary incident. The last the state hospital knew of the person was that he was being held in a New Mexico prison for another murder he had committed. The point being that the state hospital was not informed of the murder charge against the person. The state hospital had no knowledge of any violent history of the person; he was a good patient while at the state hospital and presented no management problems. Obviously there was a serious lack of communication involving the reports on the person between the sheriff's office and the state hospital.

Dr. Glover said that the incident points out an area in need of improvement and should certainly be one of the recommendations made by the Task Force members (i.e., better communication between systems).

Dr. Glover stated that a study was completed recently by the Department of Institutions of the 12 most violent people. The commonality of these people are as follows: 11 out of the 12 that were looked at had either no father or a very poor father image; the mothers were either very passive or protective, or didn't have much of a relationship with the child; their families had a long history of interactions with the legal system; 11 out of the 12 were chronic substance abusers; seven out of the 12 were high at the time of the incident; all 12 were unemployed; all 12 had no permanent residence; all 12 had a history of not wanting to be in the mental health system. Dr. Glover asked the Task Force members what kind of mental health system could be set up in order to track and monitor and assure compliance with this type of person. Dr. Diesenhaus said that from a scientific perspective the characteristics of 12 violent people could not be generalized, that the first two characteristics do not differentiate betwee the violent and non-violent.

Dr. Diesenhaus said that in the model system proposed there are no geographical boundaries established with case managers, which should be a first principle in establishing control. Dr. Glover said he sees the Task Force as possibly promising, something that they cannot deliver.

Dr. Sundell said that he felt the Task Force should be able to make some very concrete immediate recommendations about how to proceed in the present system while at the same time looking at more long term solutions.

Dr. Kleinsasser suggested that the agenda he had earlier suggested for the day would probably work as long as the scope of the recommendations was not restricted. He asked for comments. Dr. Greenwood proposed that the Task Force discuss comparatively minor proposals that would involve no huge tranfer of funds from one state agency to another, which may make the existing system work a little better and then during the afternoon address specific recommendations.

Dr. Kleinsasser suggested that the staff present the data they had collected involving a sample of cases for the Task Force members' review. Pat Malak said that what the staff put together in terms of a profile does not meet all the needs that were expressed at the last meeting - staff if very limited at the present time at the Division. Information from studies that are presently being done was pulled together along with specific cases from the law enforcement area. In the area of law enforcement, a rural and a suburban community were each looked at.

Ms. Malak said that case #5 on page 3 illustrates many of the problems we are dealing with as far as placement is concerned. Chief Ahlstrom said that is a classic case - it shows the "dumping" problem that occurs all of the time. Ms. Malak said that some of the problems in rural areas are different from those in the metro area. In the metro area is the "overlapping catchment areas" problem in trying to figure out where the person belongs. The problems in the rural areas relate to the lack of mental health facilities available, along with transportation problems and jail overcrowding problems.

Ms. Malak referred to two studies of the mentally ill in jail: one is on the Boulder county jails and was conducted by Dick Warner of the Boulder Mental Health Center. The other study is being done by the Denver Anti-Crime Council on the Denver jail and Ward 18.

Dick Warner looked at 119 individuals placed in the Boulder jail from October of 1979 to September of 1980. He found that some violent offenders are being held in jail because there was no other place for them; that people were being held in jail because they were not bad enough to be transferred to mental health facilities for inpatient care and that the judge was not willing to let those people out of jail without any alternative placement. In some cases the person being held in jail was not dangerous when brought to the jail, but after spending some time in jail became more violent and was then transferred to the mental health center or to the state hospital.

The study being conducted in Denver is somewhat preliminary and a lot of information is not yet available. Over 1,000 people were held who were identified as having mental health problems and 9.3 percent of those people were considered violent. They spent an average of 14.8 days in jail or in Ward 18 before being placed.

Dr. Sundell referred to a case he was familiar with wherein decisions regarding the patient were apparently made because of economic reasons on the part of the mental health system and personal reasons on the part of an on-call clinician.

Ms. Malak pointed out the recommendations made relating to jails. These recommendations are taken from the survey conducted by the Division of Criminal Justice and from the study conducted by Dick Warner.

Ms. Malak continued through the data pointing out the recommendations given. There was some general discussion regarding the cases presented and the recommendations shown. Dr. Pearson asked the Task Force members to be careful in viewing these statements as recommendations, when in some instances they were simply opinions expressed by a variety of practitioners across the system.

Following lunch, the Task Force members broke into two separate groups. Each group was told by Dr. Kleinsasser to come up with specific recommendations in two categories: cost and no-cost to the present system and to also state reactions to the model presented at the last meeting. The individuals within the two groups were:

Group 1	Group 2
Facilitator: Pat Malak (DCJ)	Facilitator: Bob Burke (DCJ)
Ahlstrom	Cohen
Sundell	Neale
Terrill	Glover
Schuman	Pearson
Yeager	Greenwood
Savage	Kyle
Husson	Till
	Rodriguez

The two groups reconvened at 3:00 p.m. Chief Ahlstrom presented a summary of Group 1's recommendations and Dr. Greenwood summarized Group 2's recommendations:

GROUP 1: RECOMMENDATIONS

NO-COST RECOMMENDATIONS

High Priority

IMPROVE COMMUNICATION BETWEEN SYSTEMS (i.e., criminal justice and mental health)

- COMMUNICATION BETWEEN AND WITHIN THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS SHOULD BE IMPROVED
  - Local jurisdictions should set up a mechanism for exchanging information, to include written guidelines (MHC should take lead). External help in setting up these meetings should be provided by Task Force members, Division of Mental Health or Division of Criminal Justice staff or others to provide pertinent materials regarding problems or issues to be addressed.
  - Review and change, if necessary, the statutes which limit the exchange of information needed for the proper care, treatment and followup of the dangerous mentally ill.
  - Better use should be made of the present statutes, regarding exchange of information between treatment agencies.

  - A full police report regarding the incident and criminal history should be transferred with persons referred to mental health centers by the police.
  - The state hospitals should have access to a CCIC terminal in order to check criminal history records of incoming patients.
  - A mental health "rap sheet" type report should be prepared by mental health centers and made available to other mental health or criminal justice agencies which must provide services to a dangerous mentally ill person. (This recommendation may require a legal opinion or a statute change.)
  - There should be better transfer of information between the courts and mental health facilities.
  - All information should be verified before it is transferred to another agency.

FUNCTIONS OF CURRENT SYSTEMS

- THE DEPARTMENT OF INSTITUTIONS SHOULD ASSUME GREATER COORDINATION AND SUPERVISORY FUNCTIONS OVER LOCAL MENTAL HEALTH CENTERS
- THERE SHOULD BE A STUDY OF THE NEED FOR A REORGANIZATION AT THE STATE LEVEL TO DEAL WITH MENTAL HEALTH PROBLEMS AND DETERMINE RESPONSIBILITIES
- THERE SHOULD BE AN INTEGRATED STATEWIDE SYSTEM WITH RESPONSIBILITIES DEFINED
- IF A PERSON IS KNOWN TO A MENTAL HEALTH CENTER AND HAS BEEN EVALUATED AND/OR TREATED, RE-EVALUATIONS SHOULD NOT BE REDONE IF THE PERSON MOVES TO A NEW CATCHMENT AREA. COMBINING CATCHMENT AREAS SHOULD BE A CONSIDERATION.

CROSS TRAINING

- THERE SHOULD BE CROSS TRAINING BETWEEN MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES.

STATEWIDE BED ALLOCATION

- THE SERVICE AREAS FOR THE TWO HOSPITALS SHOULD BE ELIMINATED OR REDEFINED.

Medium Priority

STATUTES

- MORE EDUCATION/TRAINING SHOULD BE PROVIDED TO MENTAL HEALTH AGENCIES REGARDING WHAT CAN AND CANNOT BE DONE UNDER THE CURRENT STATUTES

- STATUTE 27-10-107 (1) SHOULD BE CHANGED TO REQUIRE SHORT TERM TREATMENT IF THE PERSON HAS BEEN EVALUATED AND MEETS THE CONDITIONS FOR CERTIFICATION.

  THE STATUTE SHOULD READ "If a person detained for seventy-two hours under the provisions of section 27-10-105 or a respondent under court order for evaluation pursuant to section 27-10-106 has received an evaluation he shall be certified for not more than three months of short term treatment under the following conditions:
  (a) The professional staff of the agency or facility providing seventy-two hour treatment and evaluation has analyzed the person's condition and has found the person is mentally ill and, as a result of mental illness, a danger to others or to himself or gravely disabled;
  (b) The person has been advised of the availability of, but has not accepted, voluntary treatment; but, if reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, his acceptance of voluntary treatment should not preclude certification;
  (c) The facility which will provide short term treatment has been designated or approved by the executive director to provide such treatment.

FUNDING

- THE FUNDING MECHANISM FOR CERTIFYING PATIENTS SHOULD BE CHANGED TO ELIMINATE THE DISINCENTIVE FOR CERTIFYING PATIENTS.

TRAINING

- THE CRITERIA FOR INVOLUNTARY HOSPITALIZATION SHOULD BE FOLLOWED. DO NOT NEED STATUTE CHANGE.

Low Priority

- Revise mental illness statute to clarify the grey areas where the need to enforce treatment is not presently clear. A necessary change in the statute would combine the criteria for certification with those for incompetency to refuse medication. It should also include a definition of gravely disabled as incompetent to make decisions.

COST RECOMMENDATIONS (numbered in priority order)

1. THERE SHOULD BE ADDITIONAL NON-FORENSIC BEDS.

2. ADEQUATE CONTINUATION OF CARE AND FOLLOWUP CARE FOR THE DANGEROUS MENTALLY ILL SHOULD BE PROVIDED ON A NON-CATCHMENT AREA BASIS.

3. THERE SHOULD BE A FORENSIC OBSERVATION UNIT IN THE METRO AREA. PSYCHOTIC MISDEMEANANTS (NON-DANGEROUS) SHOULD BE REMOVED FROM JAIL. A LOCAL FORENSIC OR CRIMINAL JUSTICE PSYCHIATRIC UNIT IS NEEDED.

4. MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD BE AVAILABLE TO ALL JAILS.

5. THERE SHOULD BE INCREASED FUNDING TO LOCAL MENTAL HEALTH CENTERS FOR CONTINUATION OF CARE FOR NON-DANGEROUS CRIMINAL JUSTICE CLIENTS.

6. MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD PROVIDE INSTRUCTION TO JAILERS ON TREATMENT (CROSS TRAINING).

GROUP 2: RECOMMENDATIONS

NO-COST RECOMMENDATIONS (numbered in priority order)

1. A CORE FORENSIC CAPABILITY SHOULD BE DEVELOPED WITHIN EACH MENTAL HEALTH CENTER. THIS CAPABILITY WOULD CONSIST OF ONE OR MORE PERSONS SPECIALIZING IN THE DIAGNOSIS, ASSESSMENT, STATEWIDE FOLLOWUP AND CONTINUITY OF CARE OF DANGEROUS MENTALLY ILL PERSONS. THE FORENSIC SPECIALISTS WOULD RECEIVE THE TRAINING AND BE GIVEN THE AUTHORITY APPROPRIATE TO THE TASKS. EACH MENTAL HEALTH CENTER FORENSIC UNIT WOULD BE RESPONSIBLE FOR THE FOLLOWING ACTIVITIES CONCERNING THE DANGEROUS MENTALLY ILL:

   - Assessment
   - Diagnosis
   - Long term treatment plan
   - Statewide followup of dangerous mentally ill persons entering the system in that particular mental health center
   - Continuity of care for dangerous mentally ill persons released in that area
   - Coordination of actions and information within and between agencies

2. THERE SHOULD BE IMPROVED STANDARDS FOR THE TREATMENT OF PATIENTS COMBINED WITH ACCREDITATION PROCEDURES FOR THE MENTAL HEALTH CENTERS. SITE VISITS SHOULD BE MADE BY SUPERVISING OFFICIALS TO INSURE COMPLIANCE WITH THESE STANDARDS.

3. INCREASED TRAINING, LIAISON, COMMUNICATION, ACCOUNTABILITY BETWEEN LAW ENFORCEMENT AGENCIES AND MENTAL HEALTH CENTERS. AN EFFORT SHOULD BE MADE TO HAVE CONTINUITY OF PERSONNEL (STAFFING TEAMS THAT WOULD BRIDGE TWO AGENCIES AND LET IT BE A TWO-WAY PROCESS.

4. THERE SHOULD BE BETTER INFORMATION SHARING.

5. THE COURTS SHOULD HAVE THE OPTION OF HAVING COMPETENCY EVALUATIONS DONE IN THE JAILS.

6. THERE SHOULD BE A MULTI-DISCIPLINARY COMMITTEE ESTABLISHED TO REVISE AND DEVELOP MODEL STATUTES.

7. THERE SHOULD BE A STUDY TO DEFINE WHO THE DANGEROUS CLIENT IS AND TO DESCRIBE THE FOLLOWING ASPECTS OF THE DANGEROUS MENTALLY ILL POPULATION: NATURAL HISTORY; DEMOGRAPHY; FREQUENCY; AND RECOGNITION/PREDICTION.

COST RECOMMENDATIONS

1. THERE SHOULD BE INCREASED BEDS AND BETTER STAFF/PATIENT RATIO AT COLORADO STATE HOSPITAL, FT. LOGAN AND THE DENVER AREA. THERE SHOULD ALSO BE MORE INTERMEDIATE SECURITY BEDS AT COLORADO STATE HOSPITAL.

2. THERE SHOULD BE SECURE BEDS IN DECENTRALIZED LOCATIONS.

3. THERE SHOULD BE INCREASED SERVICES FOR FOLLOWUP OF ALL TYPES.

4. THERE SHOULD BE INCREASED MONEY FOR LOCKED, LONG TERM, NON-HOSPITAL BEDS.

5. THERE SHOULD BE INCREASED MONEY FOR PSYCHOLOGICAL SERVICES IN THE DEPARTMENT OF INSTITUTIONS.

6. THERE SHOULD BE SHELTERED DECENTRALIZED WORKSHOPS.

7. THE 72-HOUR HOLD SHOULD BE INCREASED TO SEVEN DAYS.

NEW MODEL (Group 2 Response)

The model needs more discussion under the areas of: laws, money, public relations and a new institution.

A date of November 13, 1981 was set for the next Task Force meeting. The meeting was adjourned.

M I N U T E S

TASK FORCE ON THE DANGEROUS MENTALLY ILL PERSON

Friday, November 13, 1981
Denver Police Department Auditorium
1331 Cherokee Street
Denver, Colorado

The Task Force on the Dangerous Mentally Ill Person (DMIP) meeting was called to order at 9:10 a.m. on Friday, November 13, 1981 with the following attandance:

PRESENT	ABSENT
Donald Abram	Patrick Ahlstrom
Tarquin Bromley	Steven Block
Irene Cohen	Richard Castro
Herman Diesenhaus	Tom Gilmore
Laurence Greenwood	Robert Glover
Doris Kyle	James Joy
Dennis Pearson	Greg Long
Ambrose Rodriguez	Leo Lucero
Youlon Savage	Betty Neale
S.Z. Sundell	Murray Richtel
Guy Till	Donald Smith
Tiana Yeager	Nancy Terrill
Sarah Sammons	Frank Traylor
John Simonet	Ruben Valdez
	Gregory Walta

The Chairman, Dr. Dennis Kleinsasser, spoke briefly stating that as a formal task force, today's meeting is expected to be the last one. There is a possibility that smaller groups may emanate from the task force to work on specific issues, he said. The goal of the task force for this meeting is to adopt the final report of the task force and to prioritize the final recommendations. Information concerning each recommendation will be given to the task force, there will be brief discussion, and then the task force members will vote on the prioritization for each recommendation.

Dr. Kleinsasser stated that time will also be spent on refining the model which had been partially developed in previous meetings. A lot of time and effort has been put forth by the task force members in producing the model and hopefully, with refinement, it can be used as a blueprint for the future. The final goal for this meeting is to discuss implementation strategy for the highest priority recommendations.

Dr. Kleinsasser asked Pat Malak to make any comments she might like regarding the final report. He personally commended the staff for the excellent job they have done in putting together the report for the task force.

Pat Malak stated that the report includes a review of the literature and statutes, data from other studies conducted in Colorado and the findings from the Division of Criminal Justice survey of mental health and criminal justice practitioners. The problems and issues are broken down into system issues with sections on entry, treatment and release. Preliminary task force recommendations are included. Discussion among the task force members on each of these issues is not included in this draft, she said, but a copy of the minutes of each meeting will be included in the final report. We will also include in the final report task force discussion of each group of recommendations.

Dr. Diesenhaus agreed with Dr. Kleinsasser that the report is excellent. He said that there are obviously two divergent poles of opinion within the task force and discussion of the issues should be included in the final report in order to accurately reflect the varying opinions. Dr. Diesenhaus said that he had specific comments regarding the report. On page 25, Table 2, a footnote should be added to reflect that the alcohol/drug abuse units of the hospitals shown do not report under the same system, or, Dr. Diesenhaus stated, they could provide parallel data to be included in the chart.

Dr. Pearson stated that there have been some changes made that took effect in July of 1981 and more that will take effect in January, 1982 that should be reflected on pages 19 and 20 of the report. The one change is in regard to "releases of criminal commitments" and the other change is in conjunction with "incompetent to proceed".

Dr. Greenwood stated that the style of the report is well done, but he felt that the content is disappointing. He felt that the problem has not been addressed, he said. The problem appears to be overwhelming in the context of current social conditions, and he thought perhaps that statement should be in the report, if one is looking for solutions. If one is looking for doing the best that can be done under current social conditions, then the report is adequate. A qualifying statement should be made, he said.

Dr. Kleinsasser asked Dr. Greenwood if he feels that the report fell short? Dr. Greenwood said that the report needs to reflect the difficulty that the task force members had in terms of coming to closure on many of the issues, within the narrow economic structure that we are dealing with.

Dr. Kleinsasser asked if perhaps the task force should have strongly suggested a specific and concrete program? Dr. Greenwood replied that he wasn't sure, but if the model were put aside the task force has not addressed the problem of what happens to these people when they're out in the community. There are only a couple of recommendations toward the end of the report regarding that issue, he said. It's obvious that these people can be a public menace when they are within the community.

As Dr. Glover pointed out in an earlier meeting, these people have no homes and no money and these are the kinds of issues we need to address, Dr. Greenwood said, in addition to some of the other technical details. The report, excellent as it is, he said, in terms of describing, collating and addressing technical details seems to bypass the larger issues.

Mr. Savage asked for clarification from Dr. Greenwood. Was he saying that the report falls short in terms of the way it was put together, or has the task force not addressed the basic issues? Dr. Greenwood replied that it was some of both. The task force did address the basic issues more than was shown in the report and that because they were more abstract, non-technical statements that the task force members stated, the report did not really cover it. There is nothing in the report that says that the members of the task force feel bad about the current situation. The introduction says that the public feels bad, but says nothing that reflects the suffering that the task force members, as individuals and as professionals have experienced in dealing with and struggling with this problem to try and do the best that can be done with it.

Dr. Diesenhaus said that he agrees - it's not the report's fault that the task force came up with two contradictory recommendations. Pages 91 and 92 of the report reflect the tension of the task force group, he said. He said that we as a group have not done anything more than to initiate some processes of dialogue with law enforcement people - even within the mental health system there are barriers over jurisdictions. This task force, in his opinion, is not going to resolve those tensions. The minutes of the meetings reflect this, he said. Much of the discussion by the task force members has focused on lack of additional resources to build a new system, therefore we are trying to "jury-rig" the old system and we are not willing to attack some of the underlying premises of the old systems.

Dr. Greenwood stated that he felt it should be said that the task force members share the public concern regarding the population (the dangerous mentally ill person); and that the recommendations the task force have finalized are the best they can come up with under the circumstances, whether you change the system or add to the current system.

Mr. Savage stated that a brief statement to that effect should be included in the beginning of the summary conclusions. He also pointed out that on page 90 of the report, under "Uniform Practices and Procedures", was what he felt to be a misstatement. The first one reads "The Department of Institutions should assume greater coordination and supervisory functions over local mental health centers." He said that 18 of the community mental health centers are private, non-profit agencies and two are county agencies. The state of Colorado buys services from them and the state portion of their budgets ranges from as much as 90 percent to as little as 20 percent. It should be couched in terms of the state deciding what services it wants to buy from those agencies rather than coordinating or controlling.

Or whether, in fact, Dr. Sundell said, the state wants to continue that manner of provision of services at all. The summary and conclusion of the report do reflect the tensions of the task force, he said, but reflect it in a way that will not be very helpful. That is, two of the four major groups of recommendations are diametrically opposite and suggest approaching the problem from totally different directions. This will just further confuse the issue, rather than help, he said. Perhaps rather than listing the alternatives, the actual discussion of the clear conflict and the two basic alternatives that have been suggested might be more helpful.

Dr. Diesenhaus stated that none of the recommendations really address the issue of "jurisdictional ownership" responsibility. He said that the task force was clearly not charged with coming up with a redefinition of the mental health system, but if the reader of the report wants to make a redefinition, let him do it.

It's important that the issue be addressed clearly, Dr. Pearson said, because that is the central focus of what has been discussed at the task force meetings - whether the existing mental health system, as a "system" really exists, and if it does exist, does it do the job? That is the basic question, he said.

It may be that the only concrete recommendation that can be made is to say "the current mental health system should be looked at very carefully and a decision made as to whether to keep it intact or scrap it and start all over." The law enforcement issues, the information issues, the treatment and custody issues all are secondary to that primary issue.

Dr. Sundell stated that the basic single question is whether the present mental health system can, in any way, provide services to the group of patients being talked about (the dangerous mentally ill). The task force should state one answer or the other to that question: yes, it can, and these are the changes necessary...or else, no, and something entirely different needs to be done for this particular group of people. It is a fundamental question and if it is not addressed the task force will not have been helpful.

Judge Abram asked what the goal of the report is. Does the legislature intend on doing something with it? If it doesn't, how much more time and effort should be put into it? If financial changes (through the legislature) are not forthcoming, then the only other changes that can be made are in the statutes. The report, generally, is more sociological than it is legal, he said. He said he can understand why the task force committee is polarized; the legal issues, which involve the criminal justice system, must be analyzed as a part of a legal system (i.e., people are going to jail, or entering the mental health system through the civil or the criminal courts) and the psychiatrists, psychologists, and sociologists are seeing people as not necessarily in the legal system but as someone who needs assistance. These are two different issues.

Mr. Savage stated that Judge Abram made some very pertinent comments, among them, the comment regarding finances, which is a very basic issue. The dangerous mentally ill constitutes a comparatively small percentage of the total number of people who are served and to suggest removal of dollars (equal to that proportion) from the budgets of the mental health centers does not make sense. The money is needed badly in order for the mental health centers to be able to adequately budget for services provided.

Dr. Kleinsasser said the task force needs to address this issue. What responsibility is the task force willing to take, through individual association, or as a smaller group to work on specific issues. Several people stated an interest in working on model legislation. Bill Woodward told the task force that the Division of Criminal Justice would make staff available to groups interested in working on the statutes, procedures, or training. There was then further discussion about what impact the report might have.

Dr. Greenwood said he didn't think there was any way at this point to determine whether the report will be useful. The report will be the most current body of useful information provided by professionals within the systems. If certain social changes evolve over the next couple of years, then the report can be useful.

Mr. Savage stated that the report captures a lot of useful information that someone will have to decide how to use in relation to current priorities.

The discussion of issues was then resumed. Dr. Pearson stated that for the dangerous mentally ill population there needs to be a supervisory, controlling, responsible state agency.

Mr. Savage said that the basic issue still is that if the state has procedures for the dangerous mentally ill and the state buys services from agencies which carry out some of those procedures, there is no problem with the state having some prescribed guidelines for those contracting agencies. The population which the task force is studying - the dangerous mentally ill, is a small population, therefore, it can be better served in some kind of centralized system which can relate to community mental health centers and other kinds of programs in some manner, but the overall notion is that there is some central coordinating body to deal with this small population. It is a special population requiring special kinds of skills to deal with it effectively, he said. That idea is one of the essential premises of the report, he said. It is a specialized population that needs some kind of central administrative control and that all parts of the system relating to this should be "plugged in" to that central mechanism.

Dr. Sundell said that deals with the underlying question. He would like to see the task force make a statement regarding this issue so that members

of the task force can either agree or disagree and then proceed. Until that is done, the same kinds of arguments over wording, etc., will occur over and over with each single recommendation that is made, because there are two obvious different directions.

Mr. Savage said that he thought the task force members were essentially agreeing that the dangerous mentally ill are a comparatively small population needing specialized services.

Dr. Sundell said that the dangerous mentally ill population is a comparatively small population, but it is a very expensive population to deal with.

Judge Abram suggested changing the wording of the first recommendation from the "Department of Institutions" to "the state."

Dr. Kleinsasser suggested that the wording of the first recommendation on page 90 be changed to be more generic; more of a statement of the output that is desired and reflect the discussion that had taken place in the meeting's minutes.

Mr. Till said that one thing he has come to believe over the past few years is that the key to the whole issue and why there is no concensus is that there is never a united front presented.

Dr. Diesenhaus stated that there is a fundamental issue here that is not being dealt with and that is the fact that community health centers are looked upon as the primary vehicle. We are talking about two parallel systems: forensic mental health and community mental health. Colorado is one of the states that in 1963 adopted the federal model which gave the community mental health center a franchise in the catchment area and that has created all kinds of tensions and problems, particularly in the Denver metro area. That model will not work for special populations. You have to reconceptualize the delivery of mental health services to look at parallel systems and decide whether you can save enough money by not having multiple evaluations of the dangerous mentally ill population, or whether you need a new source of money requiring a very detailed fiscal analysis. The conceptual, legalistic thing that perhaps Colorado should look at is moving away from the franchised model. Maybe there is a need for a new forensic mental health agency that is separate from the current agency. Maybe there's a need for a new line item in the budget. If the task force could conceptualize that and present it to the legislators perhaps it would help them break away from taking money from one pot for another pot and leaving each pot half full.

Mr. Savage said that the term forensic would have to be defined very tightly. We're talking about the dangerous mentally ill, and we work with the courts on a daily basis with many other populations, which, because they are related to the court, could, for our definition be called forensic. The dangerous mentally ill is a special population and there needs to be some special way of dealing with them.

Dr. Kleinsasser suggested that the task force start going through each recommendation, discussing each one individually, then make a final vote on each recommenation. Mary Mande reported the results of a preliminary ranking of each recommendation. The task force then discussed and modified the recommendations and voted on final priorities.

Following are the Low Cost Recommendations as agreed upon by the task force members along with the average score of the final votes and ranking of priorities. Low cost refers to minimal new money expenditures.

RECOMMENDATION	RANK	PRIORITY
• COMMUNICATION BETWEEN AND WITHIN THE MENTAL HEALTH SYSTEM AND THE CRIMINAL JUSTICE SYSTEM SHOULD BE IMPROVED.	1.45	#2
- LOCAL JURISDICTIONS SHOULD SET UP A MECHANISM FOR EXCHANGING INFORMATION, TO INCLUDE COMMON WRITTEN GUIDELINES. MENTAL HEALTH CENTERS SHOULD TAKE THE LEAD. EXTERNAL HELP IN SETTING UP THESE MEETINGS SHOULD BE PROVIDED BY TASK FORCE MEMBERS, THE DIVISION OF MENTAL HEALTH OR THE DIVISION OF CRIMINAL JUSTICE STAFF, OR OTHERS TO PROVIDE PERTINENT MATERIALS REGARDING PROBLEMS OR ISSUES TO BE ADDRESSED.	1.73	#7.5

Discussion

Uniform written guidelines should be developed. These should serve as a basis for local agreements. At the local level, mental health and the criminal justice systems should set up a mechanism for exchanging information.

- REVIEW AND CHANGE, IF NECESSARY, THE STATUTES WHICH LIMIT THE EXCHANGE OF INFORMATION NEEDED FOR THE PROPER CARE, TREATMENT, AND FOLLOWUP OF THE DANGEROUS MENTALLY ILL.	1.92	#10

Discussion

Regarding the Criminal Justice Records Act, in any case which is dismissed the access to the information regarding that case automatically becomes limited after 30 days. The information is limited to other police-type agencies and mental health centers are not included under that definition. This is unfortunate, as the mental health centers should be able to see the "rap sheets." The suggestion for this recommendation is that the statutes should be looked at from both mental health and law enforcement perspectives.

RECOMMENDATION	RANK	PRIORITY
- BETTER USE SHOULD BE MADE OF THE PRESENT STATUTES REGARDING EXCHANGE OF INFORMATION BETWEEN TREATMENT AGENCIES.	1.73	#7.5
- A FULL POLICE REPORT REGARDING THE INCIDENT AND CRIMINAL HISTORY SHOULD BE TRANSFERRED WITH PERSONS REFERRED TO MENTAL HEALTH CENTERS BY THE POLICE.	1.25	#1
- THE STATE HOSPITALS SHOULD HAVE ACCESS TO CCIC TERMINALS IN ORDER TO CHECK CRIMINAL HISTORY RECORDS OF INCOMING PATIENTS.	2.0	#11
- A MENTAL HEALTH "RAP SHEET" TYPE REPORT SHOULD BE PREPARED BY THE MENTAL HEALTH CENTERS AND MADE AVAILABLE TO OTHER MENTAL HEALTH OR CRIMINAL JUSTICE AGENCIES WHICH MUST PROVIDE SERVICES TO A DANGEROUS MENTALLY ILL PERSON. (THIS RECOMMENDATION MAY REQUIRE A LEGAL OPINION OR A STATUTE CHANGE.	2.23	#14

Discussion

The discussion centered around how this recommendation would be implemented. Where should the repository for the "rap sheet" be located; at the last mental health center where the patient stayed, or at the Department of Institutions, or the law enforcement agency? It might not be possible to implement this recommendation because of confidentiality laws. Some members felt that the recommendation should only apply to the 72-hour holds that were initiated out of some sort of criminal type behavior and a rap sheet is needed concerning those behaviors. Others felt that it is specific behavioral aspects of the individual's presentation at various times that would be of interest to other clinicians, law officers and officers of the courts.

The problem with the subpopulation (the DMIP's) is that they "fall through the cracks"; their behavior is not defined in either system. How do you get a sufficient database needed to make the decision on whether to detain or release?

RECOMMENDATION	RANK	PRIORITY
- THERE SHOULD BE A BETTER TRANSFER OF INFORMATION BETWEEN THE COURTS AND MENTAL HEALTH FACILITIES. THE SOURCE OF ALL INFORMATION SHOULD BE IDENTIFIED BEFORE IT IS TRANSFERRED TO ANOTHER AGENCY.	1.54	#4

Discussion

Mr. Savage said that he had made the recommendation originally and he said that his intent was that presentations should be based on factual data and not the emotional presentation of isolated incidents. This refers to information exchanged between agencies.

• MORE EDUCATION/TRAINING SHOULD BE PROVIDED TO MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES AND THE LEGAL SYSTEM REGARDING WHAT CAN AND WHAT CANNOT BE DONE UNDER THE CURRENT STATUTES. THERE SHOULD BE CROSS-TRAINING BETWEEN MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES.	1.75	#9

Discussion

The task force voted to combine two earlier recommendations into the one given above.

• STATUTE 27-10-107(1) SHOULD BE CHANGED TO REQUIRE SHORT TERM TREATMENT IF THE PERSON HAS BEEN EVALUATED AND MEETS THE CONDITIONS FOR CERTIFICATION.	3.3	#15

THE STATUTE SHOULD READ "If a person detained for seventy-two hours under the provisions of §27-10-105 or a respondent under court order for evaluation pursuant to §27-10-106 has received an evaluation he *shall* be certified for not more than three months of short term treatment under the following conditions: (a) The professional staff of the agency or facility providing seventy-two hour treatment and evaluation has analyzed the person's condition and has found the person is mentally ill and, as a result of mental illness, a danger to others or to himself or gravely disabled; (b) The person has been advised of the availability of, but has not accepted, voluntary treatment; but, if reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, his acceptance of voluntary treatment should not preclude certification; (c) The facility which will provide short term treatment has been designated or approved by the executive director to provide such treatment.

RECOMMENDATION | RANK | PRIORITY

Discussion

Several task force members disagreed with this recommendation, expressing the view that the way the statute change reads, it would be too convenient for people to dispose of a "nuisance" person. To require certification is going several steps backwards and a lot more people would be hospitalized. The intent of 27-10 is to make treatment voluntary. The proposed change would cause more problems for an overcrowded system. The intent of the proposed changes is to get around the cases where someone is certifiable, refusing treatment, and there are not adequate resources. The statute has a tendancy to lump all types together - it needs to be defined as to what can be done for those who are dangerous to themselves and those that are gravely disabled. The statute should be more definitional of treatment allowable for each category of mentally ill person. It should specify the nature of the condition and the nature of treatment. We can take care of those who are gravely disabled. Dangerous to others is a broad definition - maybe they can be taken care of through an imposition of a legal disability problem. This is an inpatient treatment statute; it does not speak to the outpatient program. If we're going to look at the statute, we should look at it in terms of an inpatient and outpatient program under court supervision, particularly where we talk about those people who are dangerous to others. There has been an attempt to correct the problem through §125 (by imposing the legal disability), but that was a "back door" procedure.

- A MULTI-DISCIPLINARY COMMITTEE SHOULD BE ESTABLISHED TO REVISE AND DEVELOP MODEL STATUTES. 1.62 #5

Discussion

The task force members decided that the following recommendation be included as discussion under this recommendation:

- Draft a statute to clarify the grey areas where the need to enforce medication is not presently clear for those individuals who are violent towards others. A necessary change in the statute would introduce a procedure with criteria similar to those in incompetency proceedings. This should be included in with other statutes to be looked at and possibly changed. The change in wording will address the fact that there are some "grey area people" who are violent and there is not currently a procedure to deal with them.

- THE STATE SHOULD ASSUME GREATER RESPONSIBILITY FOR DEVELOPING A CENTRALLY CONTROLLED AND ADMINISTERED SYSTEM WITH DECENTRALIZED DELIVERY FOR THE SPECIAL POPULATION OF DANGEROUS MENTALLY ILL PERSONS. THERE SHOULD BE A STUDY TO DETERMINE THE NEED FOR AN INTEGRATED STATEWIDE SYSTEM WITH RESPONSIBILITIES DEFINED FOR MENTAL HEALTH CARE DELIVERY. A CORE FORENSIC CAPABILITY SHOULD BE DEVELOPED TO CONSIST OF SPECIALISTS IN THE DIAGNOSIS, ASSESSMENT, STATEWIDE FOLLOWUP AND CONTINUITY OF CARE OF DANGEROUS MENTALLY ILL PERSONS. THE FORENSIC SPECIALISTS WOULD RECEIVE THE TRAINING AND BE GIVEN THE AUTHORITY APPRORPIATE TO THE TASKS. EACH FORENSIC UNIT WOULD BE RESPONSIBLE FOR THE FOLLOWING ACTIVITIES CONCERNING THE DANGEROUS MENTALLY ILL PERSONS:

  - assessment;
  - diagnosis;
  - long term treatment plan;
  - statewide followup of dangerous mentally ill persons; and
  - coordination of actions and information within and between agencies. 2.17 #13

Discussion

This recommendation combines the following five original recommendations:

1. The Department of Institutions should assume greater coordination and supervisory functions over local mental health centers.

   The statement should be more abstract - suggested wording: "The state should assume responsibility for developing a centrally controlled and adminstered system with decentalized delivery for the special population of the dangerous mentally ill." Some felt that

"decentralized" should be omitted and let the state decide how and what should be done. Discussion centered around implementation and financing. Others felt that centralized policy guidelines with decentralized implementation should be specified.

2. There should be a study of the need for a reorganization at the state level to deal with mental health problems and determine responsibilities.

3. There should be an integrated statewide system with responsibilities defined.

4. A core forensic capability should be developed. This capability would consist of specialists in the diagnosis, assessment, statewide followup and continuity of care of dangerous mentally ill persons. The forensic specialists would receive the training and be given the authority appropriate to the tasks.

   Each forensic unit would be responsible for the following activities concerning the dangerous mentally ill:

   - assessment
   - diagnosis
   - long term treatment plan
   - statewide followup of dangerous mentally ill persons entering the system in that particular mental health center
   - continuity of care for dangerous mentally ill persons released in that area
   - coordination of actions and information within and between agencies

   Each mental health center should have a capacity to recognize and know what to do with this type of patient, but may not be the deliverer. If this recommendation (forensic capability) is looked at as one alternative, or option then it makes sense, because in some catchment areas the local mental health center wants to and can implement it. In other catchment areas perhaps other options are needed.

RECOMMENDATION	RANK	PRIORITY

5. If a person is known to a mental health center and has been evaluated and/or treated, re-evaluation should not be done if the person moves to a new catchment area.

   The issue isn't really re-evaluation, it was intended to get at the mere fact that if someone moves, it does not necessitate the need to start all over. The system should make maximum use of available diagnostic information. Problems arise because no one will claim responsibility. There is a group of people for whom catchment area maintenance makes no sense, or there are people for whom centralized care makes sense.

   Discussion

   The task force members felt that all of the recommendations could be combined into one to insure that any changes to the system would be well thought out as to the effect on the total system. There was also a concern that people reading the report would get the impression that the task force thinks that the entire mental health system is not functioning well, In fact, the mental health centers are doing a good job for the majority of clients with mental health problems. However, the centers were not set up to deal with dangerous clients; the staffs are not adequately trained for this purpose and this proportionate amount of resources needed for the care and treatment of the dangerous mentally ill is not available.

- THERE SHOULD BE IMPROVED STANDARDS FOR THE TREATMENT OF DANGEROUS MENTALLY ILL PATIENTS COMBINED WITH ACCREDITATION PROCEDURES FOR THE MENTAL HEALTH CENTERS. SITE VISITS SHOULD BE MADE BY SUPERVISING OFFICIALS TO INSURE COMPLIANCE WITH THESE STANDARDS. 1.46 #3

  Discussion

  This is an implementation issue in terms of the current system around the larger issue being discussed, about standardized procedures, some sort of minimal level quality, etc. That if, in fact, nothing changes, if the current system is asked to handle the dangerous mentally ill persons, some method is needed to force the issue. Many problems arising are due to the

RECOMMENDATION	RANK	PRIORITY

interface of two systems, procedures and standards need to be applied to law enforcement, mental health and the courts. System interface is really the issue and that is what needs to be monitored and have some type of quality assurance mechanism.

- THE SERVICE AREAS FOR THE TWO HOSPITALS SHOULD BE ELIMINATED OR REDEFINED. 1.69 #6

Discussion

This recommendation does not totally address the problem of inadequate bed space, but it would help if the beds were equitably distributed between the two service areas. In the Colorado State Hospital (CSH) service area, where more beds are available, there is not much interest in developing alternatives.

- THE FUNDING MECHANISM FOR CERTIFYING PATIENTS SHOULD BE CHANGED TO ELIMINATE THE DISINCENTIVE FOR CERTIFYING AND/OR HOSPITALIZING PATIENTS. 3.23 #15

Discussion

Because of the high cost of providing clients with inpatient care, clients requiring this type of care are often treated on an outpatient basis. If too much is spent for inpatient care for a few clients, services cannot be provided to large numbers of clients with less severe mental health problems and relatively minor problems can escalate if left untreated.

- A STUDY SHOULD BE COMPLETED TO DEFINE THE DANGEROUS CLIENT AND TO DESCRIBE THE FOLLOWING ASPECTS OF THE DANGEROUS MENTALLY ILL POPULATION: 2.15 #12

  - NATURAL HISTORY
  - DEMOGRAPHY
  - FREQUENCY
  - RECOGNITION/PREDICTION

COST RECOMMENDATIONS

There are eight major recommendations in this section. Because it is unrealistic to expect that all of the cost recommendations will be funded in these times of tight money, Dr. Kleinsasser asked the task force members to rank the top five. The highest priority gets the highest number -- 5 is the highest. The papers were collected and Division of Criminal Justice staff computed measures of central tendency and rankings. The results and task force discussions are as follows:

Recommendation	Rank	Priority

- THERE IS A CRITICAL NEED FOR A SUBSTANTIAL INCREASE IN BOTH THE NUMBER OF SECURE AND NON-FORENSIC PSYCHIATRIC BEDS IN ORDER TO PROVIDE THE CAPABILITY OF TREATING THE DANGEROUS MENTALLY ILL. 62 #1

  - There should be more beds and a better staff/patient ratio at Colorado State Hospital, Ft. Logan, and the Denver area.
  - There should be more intermediate security beds at Colorado State Hospital.
  - There should be a greater number of secure beds in decentralized locations.

Discussion

There was some discussion that the recommendation would mean more if there was a specific recommendation as to the number of beds that are needed. However, the Division of Mental Health has the best data available and even they can't tell how many beds are needed. Mr. Till suggested that, on an intuitive basis, an estimation could be made of 250 beds required. Other members felt that the number of beds is not as important as the type of beds available (what treatment classification, what security classification, what is the cost of the bed per patient, etc.). The shortage of beds is a critical problem; when a bed is needed for a dangerous mentally ill person, it is not there, and when it's needed, it is needed immediately. After further discussion, it was suggested that a specific number of beds not be stated, but say for example, a substantial number of beds are needed.

- A MULTI-SECURITY DOMICILLIARY UNIT FOR LONG-TERM VIOLENT PEOPLE WHO ARE INCAPABILE OF SURVIVING IN AN UNSUPERVISED SETTING WITHOUT ENDANGERING OTHERS SHOULD BE BUILT. 19 #4.5

Discussion

Both low security and high security domicilliaries are needed. There are untreatable people - this

CONTINUED

2 OF 3

RECOMMENDATION	RANK	PRIORITY

fact has been ignored for years. Some people are likely to be violent if put in an unstructured setting where they can discontinue medication. There is a tendency on the part of the system to move people to a less structured program than where they function well. A statute change would be needed in order to commit people to this type of facility.

- A FORENSIC OBSERVATION UNIT SHOULD BE ESTABLISHED IN THE METRO AREA. 38 #2.5

Discussion

Forensic means those people with felony crimes before the court. Currently clients are transported to Pueblo from the metro area for observation and then psychiatrists are also flown to Pueblo from Denver to perform the evaluation.

- MENTAL HEALTH SERVICES IN THE DEPARTMENT OF CORRECTIONS SHOULD BE EXPANDED. 19 #4.5

- FOLLOW-UP AND CONTINUATION OF CARE SERVICES SHOULD BE EXPANDED 38 #2.5

  - DMIP'S SHOULD BE PROVIDED FOLLOW-UP AND CONTINUATION OF CARE SERVICES ON A NON-CATCHMENT AREA BASIS.

  - THERE SHOULD BE SHELTERED DECENTRALIZED WORKSHOPS.

  - THERE SHOULD BE INCREASED FUNDING TO LOCAL MENTAL HEALTH CENTERS FOR CONTINUATION OF CARE FOR NON-DANGEROUS CRIMINAL JUSTICE CLIENTS.

Discussion

Dr. Greenwood expressed the opinion that workshops are one of the most effective forms of treatment for some clients. Decentralized workshops are needed to provide some place for people to structure time and some place to have contact between the psychotic indiviudal and a rational individual, which is currently missing in the discharge of patients. Decentralized workshops don't have to be necessarily in catchment areas, or run the the mental health centers.

- THE 72-HOUR HOLD SHOULD BE EXPANDED TO SEVEN DAYS.

Discussion

It would provide more time for clinical work with the patient and one wouldn't have to spend as

RECOMMENDATION	RANK	PRIORITY

much time on paperwork. One would get a lot more voluntary patients, avoiding the judicial system altogether. Several members felt that this change is not necessary.

- MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD BE AVAILABLE TO ALL JAILS TO PROVIDE EVALUATIONS AND TREATMENT SERVICES. 7 #6

- MENTAL HEALTH AND ALCOHOL/DRUG ABUSE STAFF SHOULD PROVIDE INSTRUCTION (CROSS TRAINING) TO JAILERS ON TREATMENT. 6 #7.5

Following this, Dr. Kleinsasser asked the group "where do we go from here?" and opened it up for discussion.

Mr. Savage referred to the Model for Care of the Dangerous Mentally Ill: he said he would like to make a change on point #3, where it suggest that funds be held out of mental health center's allocations for the state operated programs, etc. He said he believed this should not be in the model because it creates the illusion that dollars can be removed without any harm done to the rest of the program and secondly, it creates the illusion that enough dollars can be taken out of the programs that were funded. The characteristics and the financing of a system are different ideas.

It was discussed whether to refine the model during the last hour of the meeting or whether to decide to meet again as a task force and spend a half day refining the model.

Several members felt that the development of the model was one of the most important aspects of the work of the task force, but unless they had time to fully develop it they did not feel that it should be included in the report. Mr. Bromley said that if the task force is to have any meaning the model should be completed. It needs to be in the final report and it needs to be done right. Everyone should feel comfortable with it. It would be a long-range proposal for future planning. The task force members decided that they would like to meet again to develop the model further and finalize plans for implementation of recommendations. A date of Friday, December 11, 1981 was decided upon.

The meeting was adjourned.

TASK FORCE MEETING

ON THE

DANGEROUS MENTALLY ILL PERSON

December 11, 1981

Denver Police Department Auditorium
1331 Cherokee Street, Denver

The Task Force on the Dangerous Mentally Ill Person (DMIP) meeting was called to order at 9:30 a.m., Friday, December 11, 1981 with the following attendance:

PRESENT	ABSENT
Dennis Kleinsasser, Chair	Pat Ahlstrom
Stephen Block	Donald Abram
Tarquin Bromley	Richard Castro
Herman Diesenhaus	Tom Gilmore
Larry Greenwood	Robert Glover
Dennis Pearson	James Joy
Sara Sammons	Doris Kyle
Youlon Savage	Gregory Long
John Simonet	Leo Lucero
S.Z. Sundell	Betty Neale
Tiana Yeager	Murray Richtel
	Donald Smith
	John Tagert
	Nancy Terrill
	Frank Traylor
	Ruben Valdez
	Greg Walta

Dr. Kleinsasser opened the meeting with the statement that the Task Force members would be working on finalizing a model during this final meeting. He also conveyed the regrets of several task force members who were unable to attend this meeting. Representative Betty Neale had a prior commitment, John Tagert had surgery and Gregory Long, Donald Abram, Tom Gilmore, Murray Richtel, Nancy Terrill and Doris Kyle had hearings or trials scheduled. Dr. Kleinsasser said that following today's meeting, Bill Woodward of the Division of Criminal Justice, had some comments to make concerning possible further subgroups of the Task Force (i.e., several task force members had expressed an interest in doing further work on statutes, information exchange between systems, etc.).

Dr. Kleinsasser then reviewed the process through which the preliminary model for delivery of mental health services to DMIP's had been developed. In an earlier meeting of the task force the members had broken up into three separate groups, each discussing a possible model. Following that, the entire task force met again and discussed each group's model. From these three models, a framework had been put together. Task force members

were asked to review and analyze the model in terms of the following elements, or any other element task force members felt to be important.

1. Target population

   Estimated numbers
   Needs
   Predictors and indicators

2. System Design

   Treatment
   Staffing
   Control (decentralized vs. centralized)
   Funding

3. Results and outcomes

Dr. Diesenhaus said one element he would like to see included is a focus on the target population - not just identifying who they are, but the circumstances under which violence may be committed. In addition, programs should be designed not necessarily to contain or confine people, but to reduce the probability of the occurrence of the dangerous event.

The group then discussed a definition of the target population - the dangerous mentally ill person. The question was asked if the target population would consist of those people who are predicted to be dangerous but who have never had an overt act or are they people who have had a long history of violence. Does the task force mean only the preventive detention kinds of civil commitments or are they only talking about criminal commitments? Or both?

A comment made in reply to that statement was that we are talking about prevention as well as actual violent actions, but only in the context of those individuals who are defined as being a number of things, and one is having a serious psychiatric illness or mental illness. The second criteria would be that there is some evidence that in the past, the person has shown a propensity, as a result of that illness that has caused them to put themselves or other individuals in potential danger. The charge of the task force was to focus on the group of people who have come to the attention of authorities in some way - an assessment has been made of their past; they may not have committed a dangerous act, but they can be identified as being potentially dangerous. How should they be treated from that point on?

It has been discussed in earlier meetings that the nondangerous mentally ill can be handled within the existing system, but that we do not have an adequate system for handling the dangerous mentally ill. The dangerous mentally ill person can fall into either the mental health system and sometimes the criminal justice system and what the task force is attempting to do is to interface these systems. There needs to be an inter-

vention system available to reduce the probability that a mentally ill person will engage in a dangerous act to himself or others.

After more discussion it was decided that the task force was being too abstract; an operational definition is needed (i.e., operational meaning civil commitment, referral to a forensic unit, etc.). Dr. Greenwood stated that he was attempting to make this operational definition in order to combine some understanding of the intake process with the definition, with the idea that if you have a model treatment program the people will be defined. Dr. Sundell stated that the on-line clinicians should be able to define the person's behavior as being of concern to them and have a system available to the clinician so that the patient can be treated.

It was stated that the problem showing up in society that brought about the task force and its charge is the person who has not been in the system before; who has never peen picked up; who is seriously troubled and is on the street. The task put before the group by the Department of Institutions was to determine how these people can be identified and how can the state intervene to prevent further dangerousness to others.

Dr. Greenwood stated that if a program is available, a population will be created for that program. If you define services that have been rendered to people who have been civilly committed for potential dangerousness to others, then agencies will civilly commit people who are potentially dangerous to others in order to get into the program, when it is clinically indicated.

Further discussion of the predictors and indicators of a dangerous mentally ill person was held. Among the items discussed were the deletion of sex and race on the list and the decision to label the "predictors and indicators" as concern factors. It was decided also that employment instability and housing instability should be included on the list. This list of concern factors should be listed as qualifyers to the definition.

It was stated that regardless of how the target population is defined, if a system is available that will provide treatment, that with some positive reinforcement to the referring agencies, the patients will be referred into this system and they will be defined by the clinicians handling the cases.

The definition that was decided upon by the task force members follows:

> "The dangerous mentally ill patient is defined as a person with a mental disease or defect who because of it either is dangerous to others or has a demonstrated capacity to commit violence."

The following factors should not be used as predictors of dangerousness but as variables of concern which should alert criminal justice and mental health practitioners that further evaluation may be appropriate in this case.

CONCERN FACTORS

- History of Violent Acts
  - How Frequent
  - How Serious
  - How Recent
- Drug or Alcohol Abuse
- Clinician's Judgment
- Stress in Precipitating Situation
- Employment Instability
- Housing Instability
- Socio-Economic Status
- Violent Ideas
- Paranoid Ideas
- Hallucinations
- Verbal Threats
- Bizarre Behavior
- Intense Motor Activity

The task force then discussed the estimated size of the target population: it was said that the number of the target population is important to determine approximate funding required. It was also stated that there was a hesitancy to use specific numbers when it would be difficult to validate them, but if the "perceived need" that is felt is ignored, the task force would be making a mistake. A high and low estimate based on clinical experience is appropriate.

One method of approximating is based on Colorado's population*: in Colorado, there is one patient who has been clinically assessed as dangerous to others and as having committed an offense against persons for every 1,600 people. Based on this method, a figure of 1,805 was determined. The figure of one in 1,600 is found on page 24 of the DMIP report and this figure is based on admission episodes for 1979-80. The rate is based on the 1980 Colorado population. The 1,805 figure is underestimated, it was concluded by the task force members, as any time you deal with public and state hospital and state administered systems you are under-reporting. Also, since there are duplicate admissions, not all of these people would need a bed at the same time, but the estimated number of beds would be required in order to serve the population so that when a bed is needed, it is available. The bottom line is the provision of continuity of care of services for these people, not necessarily providing them all with inpatient beds all of the time. Another reason 1,805 is a conservative estimate is that the figure does not include those already in prisons, jails and state hospitals.

As a low estimate, it was decided to use the figure of 613, as determined in the report done by Sutherland Miller. Dr. Sutherland's figures came from data collected from mental health centers on cases they felt were dangerous. He used a definition similar to the task force's definition of the dangerous mentally ill person. It was stated that recidivists should be taken into account as well.

The question was asked as to why don't we use Dr. Miller's figures for people in the community who are not getting the treatment they need? The answer

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* Colorado's population in 1980 was 2,888,834

given was that by doing that, some people are excluded (i.e., jails, detoxification centers, etc.).

Dr. Diesenhaus pointed out that on page 25 of the DMIP report, in Table 2, it shows that there is a clinical rating showing the minimum population of 3,233 which should be screened. By using a correction factor of 10 percent to correct for multiple admissions, a figure of 2,900 emerges.

The task force members agreed that there should be a qualifyer which says: the estimated number of persons includes those people needing to be in the DMIP intervention system at any level of service at any one time. The number of new admissions to that system each year and the number of discharges from that system each year should also be included. The number of new admissions will exceed the number of discharges. It was felt that these type of data could be researched thoroughly once the system is put into effect. The intent of the task force is to arrive at two estimates: 1) people in the entire program, at all levels; and 2) a gross estimate of the number of beds required.

A discussion of the Denver County Jail took place, with John Simonet stating that at this time there are 50 potentially dangerous people in his jurisdiction: 30 people within the jail itself and another 20 potentially dangerous people in the community. It is a "revolving door" situation; some people are let out into the community but will reappear at Denver County Jail within a short period of time. All of these people should be within the system; they are hard-core people with mental illnesses - but because of the present system, they are not committed. If beds were available, these people would fill them.

The next item to be discussed by the task force was the system design. The consensus of the task force was that the system should be separate from the current system and should be state managed and operated. Evaluative services is a mental health center function; intervention services would be a function of the state managed and operated system. Old dollars should not be moved - there should be new dollars. A funding mechanism should be provided as there appears to be a disincentive for mental health centers to provide needed services. If there is enough evidence to suggest that a patient be in the state system on the basis of the criteria, they should be put into the system and evaluated further. It would simplify the majority of cases, cut down costs at the evaluation level, and people would not be over-evaluated when they really don't need it.

Cases may be self generated or referred by any source and the mental health centers will be provided with additional funds for evaluative purposes.

Case managers would be employees of the state. The state should not simply contract with the mental health centers to provide a case manager. The case manager, however, could contract for services (e.g., in rural areas of the state); in the Denver metro area where the bulk of the population is, the system would own and operate facilities. Case managers would be established throughout the state. There was lengthy debate over whether specific programs

should be identified or whether case managers should be given the discretion to identify needs and create the necessary programs. Dr. Greenwood felt strongly that separate sheltered workshops are a critical need for DMIP's, but several other members thought that need for specific programs had not been researched enough to make such a recommendation. A compromise was reached whereby a statement was included to say there "may" be a need for separate workshops.

The system to treat the dangerous mentally ill should have the following characteristics:

- It should be state managed and operated to insure continuity of care
- In addition to their existing caseload, the mental health centers shall provide the evaluative services for those persons suspected of being dangerous as a result of mental illness who are referred from jails, courts, drug and alcohol facilities, or other mental health entry points. The state system shall reimburse the mental health centers for such evaluations.
- A person identified by a mental health center as dangerous as a result of mental disease or defect would be referred to the state system.
- A long term treatment plan for each client would be developed.
- Inpatient services should be centralized in one or more locations in the state. In addition, the system will provide all levels of partial care and outpatient treatment.
- Resources should be provided to purchase or create needed services. Independent sheltered workshops or boarding houses may be needed separate from currently existing community mental health centers and community corrections facilities.
- A case manager system should be established throughout the state. A case manager would arrange and monitor the necessary long term services: group and individual therapy, counseling, A.A., halfway houses or sheltered workshops. The case manager would supervise a case regardless of the type of service being delivered.
- The case manager would be employed by the state.
- The case manager would need the following resources:
  - The case manager shall have clinical training in working with the dangerous mentally ill persons.
  - Authority of a peace officer as defined in C.R.S. (1973) 27-10 and 25-1-311.

- The authority to purchase or create needed services (e.g., group and individual therapy, counseling, A.A., halfway houses or sheltered workshops).

- Authority to insititutionalize, in accordance with the law.

- Access to all client records.

- Authority to arrange for the administration of involuntary medication, in accordance with the law.

- Access to placement alternatives.

- Continuity of care procedures should be followed when exiting from the system.

Following discussion of the model, Dr. Kleinsasser stated that the staff will put together the information discussed at today's meeting and incorporate it into the final report. Copies of the final draft report will be sent to task force members for their comments. Task force members should respond back to staff with their comments on the report within one week.

Pat Malak stated that the summary and recommendations were written to reflect the concerns of the task force members in dealing with the issues; the discussion is shown for each issue identified in the request from the Department of Institutions; also shown are the final recommendations given by the task force. The recommendations along with the model will be included in an executive summary of the report. Included also will be a literature review, the problem statements and the complete minutes of the task force meetings. The low cost and the cost recommendations with their individual rankings will be included in the appendix of the report. Each recommendation is listed with the highest priorities first.

Dr. Kleinsasser officially adjourned the task force meeting and turned the meeting over to Bill Woodward of the Division of Criminal Justice.

Mr. Woodward stated that there had been a number of members of the task force who had expressed an interest to the staff in working further on certain issues (statutes, information exchange between system and cross training). He asked the members present whether they would be interested in forming subgroups to pursue these issues, and if so, the staff would be available to help.

Dr. Greenwood stated that he was interested in doing further work, but he felt the work would be of more value if the task force had the authority to continue. Officially, the task force had completed the charge given them from the Department of Institutions by issuing a report.

Dr. Diesenhaus said that out of the task force meetings has emerged the recognition of the fact that the Division of Alcohol and Drug Abuse needs to take more ownership of their share of the problems. He stated that he

will discuss this with Dr. Traylor and will also inquire at the same time about further authority to pursue the subject of subgroups continuing discussions.

Tiana Yeager said that she would discuss the subject with Dr. Glover as well. Dr. Kleinsasser said that the report will also be given to Governor Lamm, who could act as an appointing authority as well.

It was suggested that the need for further work be included in the report as well as the expressed desire of many of the task force members to continue the work.

Dr. Kleinsasser adjourned the meeting at 1:05 p.m.

APPENDIX C

APPENDIX C

CASE PROFILES OF DANGEROUS MENTALLY ILL PATIENTS

Many of the violent clients enter the system through an initial contact with law enforcement. The following is a description of types of cases encountered in a rural county, a suburban community, and in Denver. Most law enforcement agencies do not categorize offenders by offense or mental health problems. Therefore, these cases were selected by the agencies and are not a random sample, and may tend to be the worse cases rather than the typical. The case presented on the last page illustrates the interface between criminal justice and mental health agencies in handling dangerous mentally ill clients.

Suburban Community

Case 1 - Mother called police because her son was violent and had barricaded himself in the house. He had been held 11 times since 1969 on mental health holds. The police arrested him for disorderly conduct and transported him to Jefferson County Jail. Approximately four hours of officer time was involved in this case at an average cost of $10 per hour.

Case 2 - Police were called by the family of a 21 year old male who was discharging firearms. The officers saw the person walking down the street with a shotgun in his hand. He put the shotgun in his mouth. Police believed him to be suicidal. Police did not file charges and took the person to Boulder Psychiatric Institute (BPI) for a 72 hour mental health hold. BPI held the person for 45 minutes, conducted a 15 minute evaluation, and gave him back to the police who released him to a relative. Approximately 1.25 hours of officer time was involved.

Case 3 - A citizen called the police to report that a man was on top of a building shouting at spirits. The 25 year old man was taken into custody by police who transported him to BPI. Approximately two hours of officer time was involved in this case. The police have no further information on the outcome of the case.

Case 4 - A 29 year old male barricaded himself in his house after starting a fire on the porch. He aimed a gun at the police and threatened them. He was arrested for second degree arson and felony menacing and was taken by police to the Adams County Jail. He was released on bond the following morning and was not evaluated by mental health. Approximately eight hours of officer time was involved in the case. Criminal charges are being filed in this case.

Case 5 - Police were called by the attorney of a 34 year old man. The man had gone to the attorney to discuss his problems and the attorney believed the man to be homicidal and suicidal. The police and the attorney tried to find a placement for this individual. They called the Mental Health Center #1, were referred to MHC #2 who referred them to MHC #3 because the man was not in their catchment area. Mental Health Center #3 was familiar with the case but would not accept the client because he had an outstanding bill. They referred him back to MHC #2 which referred him back to MHC #1. MHC #1 said he must pay his bill and that he has a drug problem, so referred him to Drug Center #1 who said they could not take him because he was not currently on drugs and referred them back to MHC #3. MHC #3 then called Fort Logan and asked them not to accept the client. The police then told the MHC #3 that they would ask the judge to order that the person be accepted. MHC #3 then referred the client to Drug Center #2 where he was placed. He was held for approximately one hour and was released. The following day he returned to his attorney's office. The police were again called and took the client to BPI for a 72 hour mental health hold. He was held for less than three hours and was released as no risk. Approximately seven hours of officer time was required.

Case 6 - Police were called by the family of a 25 year old male because he was having mental health problems. The client's doctor arranged for the person to be placed in Bethesda. The police arranged for ambulance service to the hospital. Approximately three hours of officer time was required.

Case 7 - Police had received repeated complaints from neighbors of a woman in her late 30's. She was arrested for assaulting a day care center worker and had made a bomb threat against the center. She was taken to the County Jail and charges were filed "so that the courts would take some action." She had been placed in outpatient treatment before but would not report. She is currently receiving alcohol treatment as an outpatient under court order.

Rural Community

Case 1 - The sheriff was called by a neighbor of a man who was trying to start a fire in another person's yard. The sheriff officers picked up the 29 year old male who was displaying very strange and bizarre behavior. This individual was placed in the jail. He had been placed on a 72 hour hold once before in 1978. The mental health unit was called and evaluated the person as possibly paranoid schizophrenic, and medicated the individual since he was displaying violent behavior. The mental health center called "everyone in the state" for placement, but because he was violent, CSH was the only place that would accept him. After spending seven days in jail while placement was being arranged, the individual was transported to Pueblo for a 30 day evaluation on a court order. Four days later the sheriff was called to pick the person up from CSH and transport him back to his jurisdiction. Two days later the individual became violent again and was transported to St. Joseph's Hospital in Denver on another 72 hour hold. Ten days later the sheriff was called by St. Joseph's and told to come

pick the person up and transport him to Fort Logan for further evaluation and possible treatment. Approximately one month later, the individual was once again picked up and transported back to the community for a hearing on a pending assault charge. In total, the sheriff deputies made two round trips to Pueblo, four round trips to Denver, at a cost to the county of approximately $480 in salaries; 1648 miles @20¢ per mile = $329; eight visits from mental health for evaluation and medication at a cost of approximately $503, plus the cost of seven days jail time.

Case 2 - The sheriff's office was called to the scene of a burglary in progress. A 39 year old male was arrested a short distance from the scene and was booked into the county jail for second degree burglary. The individual was diagnosed as a borderline psychotic and spent one month and ten days in the county jail while the mental health center tried to secure a bed for him. During this time the individual created "chaos" in the jail and had to be physically restrained on several occasions. The mental health staff tried on repeated occasions to treat the individual, however, he refused treatment. The individual was then transported to Fort Logan for a 30 day hold with the pending burglary charge. The individual has since escaped from Fort Logan and is still at large.

Case 3 - A dispatcher at the sheriff's department was threatened by a 36 year old man who walked in off the street holding a knife. The individual was subdued by a deputy who was in another room. The individual was booked for felony assault. The records showed that this individual had been in a hospital in another part of the state and was released against the patient's wishes. As a result, he "acted out" in order to receive the help that he felt he needed. The individual spent three days in jail with daily medication while the mental health staff tried to place him. Because he was booked for assault, none of the placement centers would take him and Fort Logan and CSH were both full. After the three days the sheriff contacted the individual's sister who paid a $5,000 bond and got the individual admitted to a private hospital. The individual has since been placed in Fort Logan and is being evaluated for long term care.

Case 4 - The sheriff's department received a wire from a California law enforcement agency indicating that a 25 year old male from the Colorado community was wanted on a warrant in California. In reviewing their records the sheriff found that the individual had a very extensive record of juvenile crimes and mental health treatment. The individual had been charged with assault when he was 17, drinking and traffic violations when he was 18, and raping his mother when he was approximately 19. However, charges had all been dropped. The mental health records showed that as

a juvenile, the individual was referred to them numerous times by both the law enforcement agencies in the community as well as the individual's parents. The records also reflected that the individual was diagnosed as potentially "very" violent; however, the individual was uncooperative and rarely showed up for appointments. After receiving the warrant from California the sheriff officers apprehended the individual and returned him to California. Several months later he returned to the community looking for employment. Finding none in the community, he moved to the state of Oklahoma. Approximately one year later he was charged with three counts of murder and is currently serving time in the Oklahoma State Prison for the insane. However, the sheriff and mental health center have been notified that the individual may be released in the near future and return to his home community.

Case 5 - A 31 year old man was arrested by sheriff's deputies for trying to sell drugs to a deputy in a bar. The individual's record showed that he had a long history (11 years) of priors and had been previously committed to the V.A. Hospital in Denver. The mental health staff contacted the V.A. and learned that the individual had a psychological discharge from the military and had recently walked out of the V.A. Hospital without authorization. The individual spent one day in the county jail and was transferred to the Denver V.A. Hospital via a 27-10 action. The individual is still in the V.A. Hospital at this time.

Case 6 - The sheriff's department received a call from a woman who reported her car had just been stolen. Several minutes later a suspect was arrested and booked for car theft. At the time of booking it became apparent to the sheriff's deputies that the man was deranged and possibly suicidal, so they called the mental health center. The mental health staff evaluated the person as violent suicidal and started arranging to transfer the individual to CSH. One month later the individual was transported to Pueblo by two sheriff's deputies for a 30 day evaluation. During the one month in jail the individual received weekly visits from the mental health staff. The individual was transported back to the county jail to await trial for auto theft one day before this interview. The sheriff stated that CSH mails their report directly to the District Court and that often takes three or four days. As a result, he does not know, nor has the mental health center been notified, of the results of the evaluation and instructions regarding treatment or medication while the individual is in jail. The sheriff recommended that CSH change their procedures to allow the deputies to bring "sealed" reports back with them when they pick up the prisoner in Pueblo and deliver the report to the judge. The judge could inform the sheriff and mental health worker of any appropriate information. The cost to the county for this transient individual to date has been $240 in salary, $169 in transportation costs, $777 in jail time costs, and $419 in mental health costs.

Case 7 - The sheriff's office received a call from a woman who reported her 12 year old child had been sexually molested. A few minutes later a 30 year old man called the "hot line" of the mental health office and said he was going to commit suicide. The mental health staff person called the police department to pick up the individual and meet them at the hospital emergency room. Upon arrival at the hospital, the individual pulled a knife on the mental health worker and physician. When the individual was subdued he was transported to the county jail where he was identified as fitting the description of the child molester reported earlier to the sheriff's office. The mental health staff, in conjunction with the hospital and sheriff's staffs, were able to get the individual quickly into Fort Logan where it was discovered he had a long history of sex offenses. After the evaluation at Fort Logan he was returned to the county to await trial on the sexual molesting charge. At the time of his conviction on this charge the individual had spent approximately three months in jail, had been transported to and from Fort Logan once, and received approximately 12 visits from the mental health staff at a cost to the county of approximately $2994.

Case 8 - A woman called a rural sheriff's office and said she had been raped. A 22 year old male suspect was later booked in the county jail and charged with rape. The individual exhibited strange behavior so the mental health unit was called in to do an evaluation. The individual was evaluated as having severe learning disabilities and as possibly violent. The individual spent five days in jail prior to being bonded. At this time the individual is serving time in the Colorado State Penitentiary, having been convicted on the rape charge.

Case 9 - The police department was called to the scene of a burglary. They picked up a 26 year old suspect and booked him in the city jail on a burglary charge. The individual was evaluated by mental health staff during the two days he spent in jail before he was bonded. The individual was evaluated as being paranoid schizophrenic and possibly violent. The individual then voluntarily admitted himself to a hospital in a nearby community. After spending a short time at the hospital the individual left. Since he was a voluntary patient and on bond he could not be held. When he left the hospital he wrote a letter to the police chief suggesting that he was a lot like Mr. Hinckley and maybe he should kill the President of the United States. At the time of this writing the individual is still on bond and the case files have been turned over to the Secret Service for investigation.

Denver Center

Continued Treatment Program

Case 1 - A 20 year old single white female with history of treatment since age 14 has six previous psychiatric hospitalizations. Her most frequent diagnoses are psychoactive drug abuse and schizophrenia. On car theft charges she was found not guilty by reason of insanity. She was released from CSH on probation and has remained unemployed.

Case 2 - A 33 year old divorced white male is on conditional release from CSH forensic unit for sexual assault. Revocation hearing is pending. Client is presently in work training program.

Case 3 - A 25 year old single white male has a history of 15 to 20 hospitalizations in the past six years. He was convicted of assault and fined. He is currently in a protective employment program.

Case 4 - A 30 year old single white male is on pass status from CSH forensic unit for sexual assault. He has had 11 years of psychiatric treatment with numerous suicide attempts and at least six psychiatric hospitalizations. He is currently working in a family business.

Case 5 - A 23 year old single white female has two convictions for shoplifting in the past year and numerous previous arrests. She has made numerous suicide attempts and has had multiple psychiatric hospitalizations. She is currently unemployed but is using vocational rehabilitation services. She is on probation in two counties.

Short Term Treatment Program

Case 6 - A 24 year old white male, married with a young child, broke into an apartment six months ago while intoxicated. When the apartment owner woke up, the patient began to choke him to avoid being caught. The patient was not caught but was very frightened by the incident. The patient is presently involved in one-to-one outpatient care and is on medication. He was previously in treatment at age 16 and again at age 23 following suicide gestures. He has no criminal record.

Case 7 - A 39 year old white female was admitted for outpatient treatment after recently moving to Denver from an outlying county where she had started psychiatric treatment some months before. Her only other previous therapy occurred in conjunction with the sexual abuse of her son caused by her husband several years before. She was unemployed at the time of intake but had previously been employed as an aide in a nursing home. No previous criminal history was reported

but, on this occasion, it appeared as though she had acted impulsively and angrily in punishing her ten year old retarded daughter; this outburst left several superficial scrapes and scratches on the child. The case was referred directly to the family crisis unit and to their AND program for assistance. In addition, intensive work was begun with the identified patient and all of her children.

Case 8 - A 21 year old white male has two CMHC admissions since July, 1979. He was hospitalized for nine days in 1979 after pulling a knife on a man who refused to hire him. He did not attack the man and subsequently turned the knife over to him. He has a poor employment history, no known criminal record, and reports severe abuse by his father. He received outpatient treatment through August and September of 1979 and was readmitted on May 8, 1980 following a temper outburst at his aunt's home where he put holes in her wall with his fist.

Child/Adolescent Treatment Program

Case 9 - An 18 year old single white male who resides with his current girlfriend was convicted on three incidents of aggravated robbery and placed on probation in January, 1979. At this time he entered outpatient treatment at the CMHC on court order. In March, 1979 he ran away, dropped out of school, and stopped treatment. In April, 1980 he turned himself in, has completed restitution payments and has reentered treatment with his girlfriend. He has had no further arrests and is employed.

Case 10 - A 34 year old divorced black mother of three children pleaded guilty to misdemeanor child abuse and received a one year deferred sentence. She had no previous convictions or history of mental illness. The victim was her three year old nephew who had been left in her custody for several months. She has a stable employment history and sought treatment voluntarily after the incident.

Suburban Community

Case 1 - "Tom" is a 28 year old white male who murdered his estranged wife on Januray 11, 1980. He has no history of prior in-patient or partial care psychiatric treatment. He was admitted as an outpatient at Adams County Mental Health Center on October 11, 1979 and was seen for a total of eight treatment sessions between October 11, 1979 and December 27, 1979. This client was unemployed during the time of treatment. He had no known criminal history; he never exhibited any impulsivity or aggressive behavior, nor did he relate any incidences of this type of behavior in his past.

Case 2 - "Anthony" is a 30 year old Chicano male who has a diagnosis of depressive neurosis, and of passive aggressive personality. He held up a store at gunpoint, then in making his getaway, accidentally shot himself in the leg. He was convicted of armed robbery and is on probation and in mental health therapy as a contingency of his probation. Circumstances of his divorce, poverty, etc., led to the desperate holdup, and I believe he is making significant progress in treatment. He works full time and his divorce and child visitation issues are resolved.

Case 3 - "Fred" is a 26 year old white male who is unemployed and who has a diagnosis of depression, schizo-affective schizophrenia, depressed type. He was convicted of 14 out of 16 counts of hit and run, DUI, evading, etc. in Colorado Springs this year. He is considered a chronic high suicide risk. He is considered more dangerous to himself than to others, however, obviously does not think much about other people.

Case 4 - "William" is a 39 year old Chicano male who was convicted of harassment of his wife and being violent toward her. He is considered dangerous by the court. He carries a diagnosis of manic depressive illness and apparently was in a manic phase when he was violent. He is currently in a depressive phase of his illness and is cooperative in his therapy.

Case 5 - "June" is a 20 year old white female who was arrested for burglary. She had been previously arrested once on an armed robbery charge. She was in outpatient treatment beginning in October, 1974 for three months and again in July, 1975 for two months on condition of her probation. She has a sporadic history of employment, usually lasting less than several months. At disposition she had only been seen twice in outpatient treatment, having been sent to jail with plans to transfer her to Fort Logan for drug rehabilitation following sentence. No further contact was made by this agency.

Case 6 - "Ted" is a 32 year old black male with a history of psychiatric problems since the age of 17. Before moving to this catchment area, "Ted" was in Louisiana State Hospital for approximately four years having been involved in an act of arson. "Ted" came to this office voluntarily seeking medication and help in structuring his living situation, such as participation in a partial care program. Treatment did not progress very far as "Ted" was arrested a week after his first therapy session here and was charged with arson in the burning of his brother's apartment. The family was in the apartment at the time of the fire, but no one was severely injured. The apartment was severely damaged. This office was contacted by the police after "Ted" was arrested, consultation was given around medication and no further contact was requested by the police.

Case 7 - "Julian" is a 36 year old Chicano male who has a history of treatment dating back to June, 1975. His first hospitalization in June, 1976 was involuntary following an attack on his niece and nephew. He has a history of family violence and

violence toward significant others (i.e., girlfriend), but has no record of assault charges being filed. In July, 1979 this client broke into his girlfriend's apartment. He has a very poor work history, mainly being employed at a sheltered workshop. Currently he is a closed client, having moved out of the catchment area.

Case 8 - "Steve" is a 22 year old white male who has reportedly assaulted his mother and father frequently. He did break his father's arm in three places during one assaultive stage. He became involved with our agency after his mother filed a petition for certification of "Steve:. He was not certified, but it was suggested he be in treatment with the Mental Health Center. "Steve" has not held a regular job for a long time. He denies alcohol or drug problems, however, had been court ordered into a drug program but refused and went to jail instead. "Steve" attended our treatment program only two times and has refused to return. He has been made aware that treatment will be available should he choose to return.

Case 9 - "Gerry" is a 21 year old white male who has been receiving treatment at Adams County Mental Health Center in the Partial Care Program since January, 1980. The client has a history of disruptive violent and psychotic behavior and was certified for treatment on December 7, 1979. Certification was dropped on March 6, 1980. "Gerry" has been hospitalized for psychiatric reasons four times at St. Joseph's Hospital, has been placed at a Crisis House twice. He was charged with felony menacing for an incident which occurred December 4, 1979. However, the charge was reduced to illegal use of firearms, for which he pleaded guilty. He is currently a client in Partial Care, living in a Halfway House.

Rural Area

Case 1 "Gene" is a 19 year old white male with a diagnosis of paranoid schizophrenia who was recently charged with breaking and entering. Resolution of this crime was a deferred sentence to be dropped if client completes a reasonable psychiatric treatment program which he is doing. He had no previous criminal history.

Case 2 - "Bob" is a 23 year old white male with a diagnosis of paranoid schizophrenia with a long history of outpatient care and one admission to the Forensic Unit. The current charge is attempted robbery and he has previous history of legal problems including loitering, breaking and entering, and now attempted robbery. He is currently in a state hospital under a deferred sentencing arrangement. This person has no productive work history.

Case 3 - "Gordon" is a 16 year old white male with a long and early history of violence toward people including shooting his sister at age six, hitting his mother with a ball bat and other less

violent acts against a wide variety of people in between these more notable ones. He has received inpatient treatment at Fort Logan, Mt. Airy, and Bethesda. Currently he is charged with aggravated assault and to be tried in a few days. He has been in our Children's Crisis Center and followed in an outpatient basis for several years now.

Case 4 - "Chuck" is a 34 year old white male diagnosed as a chronic schizophrenic and has a long history of inpatient episodes and outpatient aftercare. He has no work history and has slowly escalated from a series of misdemeanors during the last six years to a recent incident of setting fire to a trash container when angry. Also escalating recently has been his interest in young children. He has served two to three short sentences in jail to curb his behaviors, but mostly has been referred to out and inpatient services with deferred sentencing.

PROFILE OF CONTACTS WITH CRIMINAL JUSTICE AND MENTAL HEALTH AGENCIES

LAW ENFORCEMENT	COURT	MENTAL HEALTH CENTER EMERGENCY CONTACT	DATE	PLACEMENT
Trespassing history; out of jail last week		OD-LSD-Mental health hold, police	4-23-73	
		OD-Qualude	7-19-73	
Police hold		OD-Slashed wrists, police hold	8-1-73	
			6-74	Ft. Logan, inpatient
		Need Med	9-10-76	
		Need housing, med	9-17-76	Nursing home, 6 months
		Cutting wrists	5-11-77	Prior to 1-75 left for home
Jail for hitching			8-9-77	CSH 1-11-74 probation
		OD-Thorizine	8-9-77	
Evicted from apartment			11-21-77	
		OD-Suicide attempt	3-28-77	
Jail-disturbing the peace		Suicide attempt	9-20-78	
		Suicide attempt	11-7-79	
		Fracas with landlady	11-12-79	
		Report that apartment is trashed	11-17-79 11-21-79	
Arrest for tearing up rented room		Jail	11-23-79	

(Continued on following page)

LAW ENFORCEMENT	COURT	MENTAL HEALTH CENTER EMERGENCY CONTACT	DATE	PLACEMENT
In jail		Suicide: ideation. Recommendation: keep in jail	11-26-79	
In jail			11-27-79	
In jail			1-16-80 1-16-80	Residential treatment
Back in jail in violation of probation. Isolation, throwing food.			5-14-80	
Set apartment on fire			6-80	
	7-7 Trial hearing	Demanded med., created disturbance MHC	6-10-80	
Still in jail	Will be released 30 days/suspended sentence for arson		8-80	
Jail: criminal mischief and indecent exposure		Suicide attempt	11-14-80	
In jail		Poured ink in eyes	11-19-80	
Criminal history in police files back to 12-4-70				

APPENDIX D

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DESCRIPTION OF THE SYSTEM

The person who, as a result of mental illness, has proved or appears to be an imminent danger to others or to him/herself calls into action the resources and services of a variety of mental health and criminal justice agencies. If a violent act is committed or dangerous behavior is exhibited, the police, sheriff, jailer, mental health centers, district or county attorneys, judiciary, public defenders, probation officers and parole agents may all become involved during the treatment and disposition processes. In this regard, law enforcement, court, corrections and mental health practitioners and agencies must comply with statutory provisions designed to insure the public's safety and the mentally ill individual's civil rights.

Statutory authority and responsibility delegated to criminal justice and mental health agencies for handling and treating the dangerous mentally ill person are described in the sections which follow.

CRIMINAL JUSTICE AGENCIES

Law Enforcement/Jails

Actual or apparently imminent dangerous actions of the mentally ill usually invoke some sort of emergency procedure. Colorado law CRS 1973, 27-10-105 provides that when such a situation occurs "a peace officer or a professional person, upon probable cause and with such assistance as may be required, may take the person into custody...and place him in a facility designated or approved... for a 72-hour hold and evaluation." Emergency procedure may also be invoked upon an affidavit sworn to or affirmed before a judge. The court may then order the person described in the affidavit to be taken into custody for a 72-hour hold and evaluation in a designated or approved facility or in a private facility consenting to the enforcement of standards governing the hold and evaluation. When a person is taken into custody under these circumstances, the person may not be detained in a jail or other place used for the confinement of persons charged with or convicted of criminal offenses unless no other suitable place of confinement for treatment and evaluation is readily available. If it is necessary to hold a mentally ill person in a jail, he/she must be detained separately from those charged or convicted of penal offenses and may not be held for more than 24 hours (excluding Saturdays, Sundays and holidays) before being transferred to a facility designated or approved for 72-hour hold and evaluation.

When a private citizen petitions the court to request an evaluation of another person's perceived dangerous mentally ill condition, the court may, in accordance with CRS 1973, 27-10-106 as amended, authorize a peace officer

to take the alleged dangerous mentally ill person into custody for placement in a designated 72-hour hold and evaluation facility.

The Emergency Procedure section of the Department of Institution's Procedure Manual to Implement the Case and Treatment of the Mentally Ill Act (revised July, 1979) lists the following documentation requirements to be carried out by police officers who take into custody or detain a mentally ill person in an emergency situation:

1. The peace officer must fill out an Emergency Mental Illness Report and Application, stating the circumstances under which the person's condition was called to his attention.

2. The peace officer must state that he believes, as a result of personal observation, or as a result of information obtained from others which he believes to be reliable, that the person is mentally ill and, as a result of mental illness, an imminent danger to others or self, or gravely disabled.

3. The peace officer must state when the person was taken into custody.

4. The peace officer must state who brought the person's condition to his/her attention.

5. The original form must be left with the evaluation and treatment facility and made a part of the person's evaluation and treatment record for at least five years.

6. A copy of the form must be given to the person being detained for evaluation and treatment.

If a person detained for 72-hour evaluation and treatment or certified for short-term treatment needs to be transported to another facility for evaluation and treatment, the Procedure Manual states that the court may issue an order directing the sheriff to deliver the person to the designated facility: if the safety of the person or of the public requires transport by the sheriff; and the attending professional person reports to the court the reasons for the need for sheriff transport; and the court is satisfied with the report.

Prosecution

As provided in CRS 1973, 27-10-111, in a county or city and county having a population exceeding 100,000, the county attorney, or a qualified attorney acting for the county attorney appointed by the district court, conducts hearing proceedings associated with certification of the mentally ill person for short-term treatment (three months), extension of short-term treatment (three months) or for long-term treatment (considered after five months of consecutive short-term treatment). In all other counties, the district attorney, or a qualified attorney appointed by the district court, conducts such hearings.

In cases where criminal charges have been filed against a mentally ill person, the defendant and the district attorney may consent to deferred prosecution or deferred judgment. In such instances, the court may, as provided in CRS 1973, 16-7-402, require the defendant to obtain treatment for a period not to exceed one year.

If a plea of not guilty by reason of insanity is entered and probable cause is not established during a preliminary hearing prior to trial of the insanity issue, the case is dismissed. The court may, however, as stated in CRS 1973, 16-8-103, "order the district attorney to institute civil proceedings pursuant to article 10 of title 27, CRS 1973, if it appears that the protection of the public or the accused require it.

When a plea of not guilty by reason of insanity is accepted and the report of the sanity examination is received by the court, the case is required by CRS 1973, 16-8-105 to be immediately set for trial to a jury on the issue raised by the plea of not guilty by reason of insanity. The defendant may waive jury trial in all cases except class 1, class 2 and class 3 felonies. Jury trial may also be waived in these three cases if the court and the district attorney consent. Once any evidence of insanity is introduced, the people, represented by the district attorney, have the burden of providing sanity beyond a reasonable doubt.

When a person who has been found not guilty by reason of insanity may be released the chief officer of the hospital in which a defendant has been committed determines that the defendant no longer required hospitalization because he is "no longer likely to be dangerous to himself, to others, or to the community in the reasonably forseeable future." CRS 1973, 16-8-116 requires that a report of examination equivalent to a release examination be furnished to the court, the prosecuting attorney and the counsel for the defendant. The district attorney may contest the release within 30 days after receiving the report.

Public Defense

When an evaluation for mentally ill persons is ordered by the court, CRS 1973, 27-10-106 requires that the petition for such an evaluation contain the name, address and telephone number of the person's attorney or, if there is no attorney, a statement "as to whether, to the best knowledge of the petitioner, the respondent meets the criteria established by the legal aid agency operating in the county or city and county for it to represent a client." According to the Procedure Manual (revised July, 1979) published by the Colorado Department of Institutions to implement Rules and Regulation for the Care and Treatment of the Mentally Ill Act. (Article 10 of Title 27, CRS 1973, as amended), "each person voluntarily or involuntarily admitted to a 72-hour evaluation and treatment facility shall be advised by the facility director or his/her duly appointed representative: that he/she has the right to retain and consult with an attorney at any time, and that if he/she cannot afford an attorney, one will be provided by the court without cost."

If criminal charges have been filed against a mentally ill person, CRS 1973, 16-8-119 provides that "upon motion of the defendant and proof that he is indigent and without funds to employ physicians, psychologists, or attorneys to which he is entitled...the court shall appoint such physicians, phychologists, or attorneys...at state expense."

If, as provided in CRS 1973, 16-8-103, the plea of not guilty by reason of insanity is entered at the time of arraignment or permitted by the court "for good cause shown" at any time prior to trial, it must be pleaded orally by either the defendant or his counsel. If the defendant refuses to permit the entry of the plea, counsel may so inform the court which then "shall conduct such investigation as it deems proper."

The plea of not guilty be reason of insanity includes the plea of not guilty; therefore, if the defendant is found to be sane at the time the offense was committed, the court, unless it has reason to believe the defendant incompetent to proceed, must immediately set the case for trial in compliance with CRS 1973, 16-8-105 and, as provided in CRS 1973, 16-8-119, a defendant who meets the criteria for indigency is entitled to counsel at public expense.

When the court makes a preliminary finding that the defendant is or is not competent to proceed, CRS 1973, 16-8-111 requires the court to immediately notify the presecuting attorney and defense counsel of the preliminary finding. The preliminary finding becomes final if "neither the prosecuting attorney nor defense counsel request, in writing, a hearing within a time limit set by the court." When, as a result of a restoration hearing, initiated and conducted in accordance with CRS 1973, 16-8-113, the court determines that a defendant is restored to competency, the court must resume or recommence the trial or sentencing proceedings or order the sentence carried out. The indigent defendant is entitled to counsel at public expense in this situtation, also. The statute specifies that "evidence of any determination as to the defendant's competency or incompetency is not admissible on the issues raised by the pleas of not guilty or not guilty by reason of insanity" and also provides that the defendant be credited with any time spent in confinement "against the maximum and minimum of any term of imprisonment imposed after restoration of competency."

Courts

The courts have the ultimate responsibility for striking a balance between public safety and individual rights. The Care and Treatment of the Mentally Ill Act (CRS 1973, article 10, title 27) describes the role of the court in evaluating, committing, treating and terminating treatment of the mentally ill person whose behavior has caused mental health and/or criminal justice practitioners, in the interest of public safety, to implement procedures for care and treatment in a secure setting.

In an emergency situation, CRS 1973, 27-10-105 authorizes the court, upon sworn affidavit by a peace officer or professional person, to order the

dangerous, mentally ill person to be taken into custody and placed in an approved or designated facility for a 72-hour hold and evaluation. In addition, any individual may petition the court to involuntarily hold and evaluate a person who appears to be mentally ill and, as a result of mental illness, appears to be a danger to others or to himself. The court is required to "designate a facility...or a professional person to provide screening of the respondent to determine whether there is probable cause to believe the allegations." If the screening report indicates probable cause exists and the mentally ill person will not voluntarily accept evaluation, the court must issue an order for 72-hour hold and evaluation. Within those 72 hours, the person held must be released, referred for further care and treatment on a voluntary basis or certified for short-term treatment not to exceed three months. Certification is filed with the court when a dangerous mentally ill person will not accept voluntary treatment or if reasonable grounds exist to believe the person will not remain in a voluntary treatment program. Certification places the dangerous mentally ill person in the custody of the designated short-term treatment facility.

The professional person in charge of the evaluation and treatment of the dangerous mentally ill client may, as provided by CRS 1973, 27-10-108, file an extended certification which can be for no longer than three months. After five consecutive months of short-term treatment, but within six months after the date of original certification, professional staff of the facility providing short-term treatment may petition the court, pursuant to CRS 1973, 27-10-109 for long-term care and treatment if there is reason to believe the person being treated is mentally ill and dangerous. A jury trial may be requested by the patient or his/her attorney. If the court or jury determine that long-term care and treatment is appropriate, the court must issue an order for care and treatment for a term not to exceed six months. This term may be extended as many times as the court orders, but no single extension period may exceed one year. If requested by the dangerous mentally ill person or his/her attorney, the court must conduct a hearing to review certification for original and extended short-term treatment and for long-term care and treatment.

When a certification or extended certification is terminated, the professional person in charge of the facility having custody of the client must notify the court in writing within five days. If a person being treated escapes before termination of certification CRS 1973, 27-10-110, as amended, provides that the excapee "may be returned to the facility by order of the court without a hearing or by the director of the facility without order of court."

As provided in CRS 1973, 27-10-123, proceedings governing emergency situations, court-ordered evaluation or certification for short-term treatment covered by this Act "shall not be initiated or carried out involving a person charged with a criminal offense unless or until the criminal offense has been tried or dismissed; except that the judge of the court wherein the criminal action is pending may request the district or probate court to authorize and permit such proceedings."

Criminal court proceedings governing insanity, incompetency and release are defined and described in article 8, title 16, CRS 1973, as amended. An insane person is one "who is so diseased or defective in mind at the time of the commission of an act as to be incapable of distinguishing right from wrong with respect to that act, or being able so to distinguish, has suffered such an impairment of mind by disease or defect as to destroy the willpower and render him incapable of choosing the right and refraining from doing wrong is not accountable; and this is so howsoever such insanity may be manifested, by irresistable impulse or otherwise." The statute also cautions, "care should be taken not to confuse such mental disease or defect with moral obliquity, mental depravity, or passion growing out of anger, revenge, hatred, or other motives, and kindred evil conditions, for when the act is induced by any of these causes the person is accountable to the law."

Insanity may be used as a defense against criminal charges by entering a specific plea at the time of arraignment or, if the court "for good cause shown" permits, the plea may be entered at any time before trial of the case. A defendant who does not "raise the defense" as provided in section CRS 1973, 16-8-103, "shall not be permitted to rely upon insanity as a defense to the crime charged, but when charged with a crime requiring a specific intent as an element thereof, may introduce evidence of his mental condition as bearing upon his capacity to form the required specific intent."

The plea of not guilty be reason of insanity includes the plea of not guilty and, pursuant to CRS 1973, 16-8-104, the issues raised by such a plea must be tried "separately to different juries." The sanity of the defendant must be tried first. When the not-guilty-by-reason-of-insanity plea is accepted, the court must commit the defendant to a sanity examination for the purpose of developing information relevant to determining the sanity or insanity of the defendant at the time the crime was committed and also to determine the defendant's competency to proceed. If a jury or the court finds the defendant not guilty by reason of insanity, the court is required to commit the defendant "to the custody of the department of institutions" until he/she becomes eligible for release.

Nothing in the statutes or court rules prevents the court from using the services of psychiatrists in private practice to conduct forensic (and civil) evaluations. In such cases, fees are negotiated on a case-by-case basis.

If and when the question of the defendant's eligibility for release is contested, section CRS 1973, 16-8-115 requires the court to order a release examination if a current one has not been furnished or if the prosecuting or defense attorney moves to have the defendant examined at a different institution or by "differing experts." The burden of proof is on the party contesting the report of the "chief officer" of the institution having custody of the defendant. If the court or jury finds in favor of release, the court may impose terms and conditions "which it determines are in the best interests of the defendant and the community." If the verdict is against release, the court must recommit the defendant.

When the director of the institution having custody of the defendant reports to the court that the defendant no longer requires hospitalization, the court must, in compliance with CRS 1973, 16-8-116, order the discharge of the defendant, "unless before that day, the district attorney notifies the court that the report is contested."

Legally, a defendant suffering from a mental disease or defect which makes him incapable of understanding the nature and course of the criminal proceedings against him or of participating or assisting in his defense or cooperating with the defense counsel, is incompetent to proceed. The judge must, if he has reason to question the defendant's competency, suspend the proceeding and determine competency or incompetency pursuant to CRS 1973, 16-8-111. Burden of proof is on the party asserting the incompetency of the defendant. If the defendant is found to be competent, the judge must order the suspended proceedings to continue, or, if a mistrial has been declared, to reset the trial at the earliest possible date. Jeopardy is not an issue under these circumstances. If the defendant is found to be incompetent, the court must commit him to the Department of Institutions until such time as he is found to be competent to proceed.

Restoration to competency may be accomplished through procedure mandated by section CRS 1973, 16-8-113. A court may order a restoration hearing on its own motion or on the motion of the prosecuting attorney or of the defendant. The court must order a hearing if the head of an institution to which the defendant is committed or a physician who has been treating the defendant files a report stating the defendant is competent to proceed. If the question is contested, burden of proof is on the party asserting competency.

If, at the restoration hearing, the court determines the defendant to be competent, the court must "resume or recommence the trial or sentencing proceedings or order the sentence carried out." The law also provides that any time the defendant spent in confinement while committed as incompetent to proceed must be credited by the court against the maximum and minimum of any prison term imposed after restoration to competency. When the court finds the defendant still incompetent to proceed, the court may "continue or modify any orders entered at the time of the original determination of incompetency and may commit or recommit the defendant or enter any new order necessary to facilitate the defendant's restoration to mental competency "is not admissible on the issues raised by the pleas of not guilty or not guilty by reason of insanity.

Procedure for treatment of a mental condition in connection with deferred prosecution or probation is covered by section CRS 1973, 16-7-402. The court may require the defendant to obtain treatment for any mental condition, and the defendant may be permitted to obtain this treatment from "any psychiatrist and at any suitable public or private mental health facility of his choosing." If the defendant so requests, the court may order the department of institutions "to admit him for rehabilitative treatment to one of the mental institutions under its control, for a period not to exceed one year."

Probation

Plea discussions and agreements in criminal proceedings may result in the placement of someone defined as dangerous mentally ill under the supervision of a probation officer. For example, in any case in which mental health treatment is authorized in connection with a deferred prosecution or probation, section CRS 1973, 16-7-402 permits the court to require a defendant to obtain treatment for a "mental condition." The court may permit the defendant to obtain such treatment from any psychiatrist and "at any suitable public or private mental health facility of his choosing." This practice is consistent with the Rules and Regulations governing the Care and Treatment of the Mentally Ill Act which provide that "physical restraint/seclusion may be used only when other less restrictive means cannot produce the control necessary to prevent harm to the patient of others."

A person charged with a sex offense may also be placed on probation even though mental health treatment is prescribed by the court. Section CRS 1973, 16-13-207 requires the court to commit a sex offender to Colorado State Hospital, the University of Colorado Phychiatric Hospital, or the county jail and to undergo psychiatric examination. Written reports independently written by two examining psychiatrists must contain their opinion as to "whether the defendant, if at large, constitutes a threat of bodily harm to members of the public." The written reports must also contain opinions concerning whether the defendant could benefit from psychiatric treatment and could be adequately supervised on probation.

Corrections

Section CRS 1973, 17-23-101 (3) empowers the executive director of the Department of Corrections to transfer a dangerous mentally ill inmate to the Colorado state hospital or Fort Logan mental health center "for safekeeping" when the inmate "cannot be safely confined in any other facility or institution for the care and treatment of the mentally ill." This law also provides that a person adjudged to be mentally ill by a "court of competent jurisdiction" cannot be transferred to any penal institution or reformatory unless he is found to be so dangerous that he cannot be "safely confined" in Colorado state hospital or Fort Logan mental health center.

Transfer of a person alleged to be too dangerous for safe confinement in the state hospital or Fort Logan mental health center must comply with the provisions of CRS 1973, 17-23-103 governing the rights of the person being treated. The statute entitles the dangerous mentally ill person to (1) written notice of the facts upon which the allegation of dangerousness is based; (2) an impartial hearing conducted before transfer, unless an emergency situation requires, for safety and security reasons, that the hearing be held "within a reasonable time after such transfer"; (3) an opportunity to call witnesses and present evidence in his own behalf if security and safety is not jeopardized; (4) a written statement as to

evidence relied on and reasons for any finding supporting recommendations for transfer; and (5) assistance of legal counsel, at public expense if the patient is indigent. The Department of Corrections must provide transferred patients with psychiatric care and treatment "substantially equivalent to that provided patients confined at the state hospital or Fort Logan mental health center.

Parole

Although the parole agent's role with regard to supervision of the dangerous mentally ill is not specifically defined by statute, certain provisions of statutes concerning the care and treatment of the mentally ill and the right to treatment involve the services of the parole agent. First, CRS 1973, 27-10-116, as amended, guarantees to any person receiving evaluation or treatment under the Care and Treatment of the Mentally Ill Act the right to "medical and psychiatric care and treatment suited to meet his individual needs and delivered in such a way as to keep him in the least restrictive environment possible." Secondly, CRS 1973, 17-23-101 provides that "No person...adjudged to be mentally ill...shall be transferred to any penal institution unless he is so dangerous that he cannot be safely confined in the state hospital or Fort Logan mental health center." Compliance with these provisions requires that a convicted sex offender, for example, or a state prison inmate who is mentally ill but not too dangerous to be treated at a state mental health facility must be transferred to Colorado State Hospital. When eligible for parole, these offenders will be paroled from the mental health facility under the supervision of a parole agent.

In addition, the parole agent retains supervision of a parolee who commits a dangerous act attributed to mental illness although the parolee may be confined to a mental health facility for care and treatment:

> To secure for each person who may be mentally ill such care and treatment as will be suited to the needs of the person and insure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;
>
> To deprive a person of his liberty for purposes of treatment or care only when less restrictive alternatives are unavailable and only when his safety or the safety of others is endangered;
>
> To provide the fullest possible measure of privacy, dignity, and other rights to persons undergoing care and treatment for mental illness;
>
> To encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness.

The legislative declaration concludes, "To cary out these purposes, the provisions of this article shall be liberally construed."

General policies of the Department of Institution's Rules and Regulations include requirements and responsibilities associated with emergency procedures. These policies require each designated and placement facility "to develop and implement written staff procedures for managing patients' assaultive or self-destructive behavior and for humane administering of confinement or physical restraint adequate to protect both the patient and those around him/her when a patient is determined, by a professional person, to be in imminent (or immediate) danger of hurting him/herself or others, and treatment of this condition is only possible with the use of seclusion and/or restraints." Emergency procedures employed by designated and placement facilities must conform to the rules and regulations governing physical restraint, seclusion and the right to refuse medications.

MENTAL HEALTH AGENCIES

State-owned facilities, agencies that contract with the state, private treatment resources and voluntary mental health resources comprise the spectrum of mental health services available to the residents of Colorado. The Department of Institutions is designated the official mental health and mental retardation authority. The Department has three major divisions: Mental Health, Developmental Disabilities, and Youth Services.

Colorado law C.R.S. 1973, 27-10-126, requires the Department of Institutions to promulgate Rules and Regulations for the Care and Treatment of the Mentally Ill. These Rules and Regulations specify that services for the mentally ill who are detained involuntarily be provided by either designated or placement facilities. A designated facility is (1) a 72 hour treatment and evaluation facility, pursuant to 27-10-105 and 106, C.R.S. 1973, or (2) a short and long term treatment facility, pursuant to 27-10-107 and 109, C.R.S. 1973. A placement facility is a private facility licensed by the Colorado Department of Health as a general hospital, a psychiatric hospital, a community clinic and emergency center, a convalescent center, a nursing care facility, an intermediate care facility; or, a residential facility or a community mental health center or clinic under contract with the Department of Institutions, which is used in order to provide care and security to any person undergoing mental health evaluation or treatment by a designated facility, pursuant to regulations governing the criteria for such facilities.

The Department of Institutions is also responsible, through authority delegated to its Division of Mental Health, for administering and monitoring state and contractual community and private programs and facilities to assure compliance with the legislative intent of Article 10, Title 27.

Division of Mental Health

The Division of Mental Health is authorized to operate the two state hospitals, to purchase services from community mental health centers/clinics and other human service agencies, to regulate facilities designated as 72 hour treatment and evaluation facilities, and to otherwise

plan for and direct the mental health program. Responsibilities of the Division of Mental Health also include facilitating cooperation among and between components of the Colorado mental health services delivery system and other human service agencies; regulating designated agencies; and monitoring the programs and services of the state mental hospitals and the community mental health centers and clinics to "ensure compliance with standards, to assess the quality of services, and to assist the agencies in improving services."

In addition, according to the 1980-1985 Colorado Mental Health Plan, the Division "provides consultation on planning, programming, funding and evaluation to all components of the system, to the Governor's office and to other state offices and agencies." A focus on advocacy functions involves "initiating and promoting the development of high quality, reasonable cost mental health programs to serve clients most in need in a manner that protects their privacy, dignity, and rights."

Statewide mental health planning is carried out to address the requirements of the Community Mental Health Centers Act of 1975 (Public Law 94-63, as amended). In further compliance with PL 94-63, the Colorado Mental Health Council functions as the official advisory body to the Division of Mental Health with regard to policy, operations and finances and also approves the State Mental Health Plan. A majority, but not more than sixty percent of the Council's twenty-five members, are not direct or indirect providers of mental health services. At least forty percent of the membership are direct or indirect providers of such services.

Problems and needs associated with the dangerous mentally ill person pose a particular challenge in planning and operating mental health facilities and programs. Services related to these problems and needs provided by Colorado State Hospital, Fort Logan Mental Health Center and community mental health centers/clinics are presented in the following three sections.

Community Mental Health Centers/Clinics

Location: Statewide in 20 mental health catchment areas

Total Staff: full time - 1555
part time - 349

Total Operating Budget (FY1980-81): $41,092,385

Sources of Revenue:

State funds	$16,637,108
Federal funds	5,109,931
Fees, titles, ins.	6,305,251
County/municipal	5,819,880
Donated and in-kind	4,365,295
School districts	479,302
Other	2,875,618

Community mental health centers or clinics provide services which conform to Colorado law (27-1-201 et.seq., as amended) and federal law (42 USC 2681 et.seq., as amended by PL 94-63). Community mental health was officially initiated with the passage of the Federal Community Mental Health Centers Act of 1963 under which the federal government began accepting some responsibility for funding and overseeing the provision of services in a community setting.

To provide such services, Colorado is divided into 20 mental health catchment areas, each of which contains a community mental health center designated by the Division of Mental Health as the agency responsible for assuring delivery of comprehensive mental health services in a given geographic area. Catchment areas conform with the boundaries of the 13 state planning regions and with the boundaries of the three Health Service areas. (See list on following page.) In addition to the 20 mental health centers, there are three specialized clinics, approved by the Division of Mental Health for purchase of services. Although all three clinics (Children's and Adolescents' Mental Health Service at Children's Hospital, Denver Mental Health Center and Servicios de La Raza) are located in Denver, the services they provide are not limited to a particular catchment area.

As defined by 27-1-201, C.R.S. 1973, a "community mental health center" means a physical plant or group of services "under unified administration or affiliated with one another." In addition, to qualify as a community mental health center, an agency must provide the following five essential services:

- inpatient services: in-hospital, 24 hour care at a hospital licensed by the Department of Health, including services for diagnosis, emergency, and short term crisis care which can not be provided in a less restrictive and expensive setting;

- outpatient services: treatment services which are generally less intensive and of shorter duration per treatment than inpatient or partial care hospitalization. Services include, but are not limited to, diagnostic evaluations and treatment with special emphasis on populations most in need; diagnostic screening and referral services for courts and other appropriate agencies and organizations; and followup and aftercare for residents from the area released from inpatient facilities and other treatment programs;

- partial hospitalization: treatment services generally of a more intensive nature than outpatient services, and which involve more than two hours, but less than 24 hours of care per daily therapeutic episode, with the exception of sheltered workshop contacts which may be of any length;

- emergency services: services, available by telephone and in face-to-face contact with professional staff, as appropriate, 24 hours a day; and

HEALTH SERVICE AREAS, PLANNING REGIONS, COUNTIES AND CATCHMENT AREA MENTAL HEALTH CENTERS AND CLINICS

Health Service Area	Colorado Planning Region	Counties	Catchment Area Mental Health Center/Clinic
1	1 & 5	Logan, Sedgwick, Phillips, Yuma, Washington, Morgan, Elbert, Lincoln, Kit Carson, Cheyenne	Centennial Mental Health Center, Inc.
1	2a	Weld	Weld MH Center, Inc.
1	2b	Larimer	Larimer County MH Center
1	3a	Adams	Adams County MH Center
1	3b	Arapahoe, Douglas	Arapahoe MH Center
1	3c	Boulder	MH Center of Boulder Co.
1	3d	Jefferson, Gilpin, Clear Creek	Jefferson County Mental Health Center
1	3e	Southeast Denver	Bethesda Community MH
1	3f	Northwest Denver	Health & Hospitals MH
1	3g	Northeast Denver	Park East MH Center
1	3h	Southwest Denver	Southwest Denver Community Services
1	3i	Arapahoe, Adams	Aurora MH Center
2	4	Park, Teller, El Paso	Pikes Peak MH Center
2	6	Crowley, Kiowa, Prowers, Bent, Baca, Otero	Southeastern Colorado Family Guidance Center
2	7	Pueblo, Huerfano, Las Animas	Spanish Peaks MH Center
2	8	Saguache, Mineral, Rio Grande, Alamosa, Costilla, Conejos	San Luis Valley Comprehensive Community MH
2	13	Lake, Chaffee, Fremont, Custer	West Central MH Center
3	9	Dolores, Montezuma, La Plata, San Juan, Archuleta	Southwest Colorado MH Center
3	10	Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale	Midwestern Colorado MH Center
3	11 & 12	Moffat, Routt, Jackson, Grand, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Summit	Colorado West Regional MH Center

- consultative and educational services: assistance given to other human service agencies, health care professionals, and human service oriented groups to assist them in better meeting the mental health service needs of their clients and efforts to inform professionals and lay persons about any aspect of mental health, mental health problems, and mental health services.

The foregoing essential services are merely itemized in the law. They are defined in the Standard/Rules and Regulations for Mental Health Centers and Clinics developed by the Division of Mental Health in March 1977. A clinic provides fewer than the five essential services, but must, at a minimum, provide outpatient,emergency and consultation and education services.

The primary emphasis of community mental health is to provide services as close to the client's home as possible and in the least intensive setting consistent with the individual's clinical needs. For these reasons, catchment area centers perform the preadmission screening function for all clients who do not fall into those categories which require direct referral to one of the state hospitals.

Fort Logan Mental Health Center

Location: Denver

Total Staff: 510 full time employee positions

Bed Capacity: 333 licensed beds - all programs

Total Operating Budget (FY 1980-81): $12,735,448

Sources of Revenue:		
	General Fund	$6,167,804
	Cash funds, patient fees	4,770,098
	Cash funds, other state agencies	1,786,643
	Federal funds	11,903

Fort Logan Mental Health Center provides services in compliance with 27-15-101, C.R.S. 1973 et.seq., as amended. The following treatment and rehabilitative programs are available at Fort Logan: Adult Psychiatry; Alcohol Treatment; Geriatric, Deaf, and Aftercare Services; Children and Adolescent Treatment; and, Vocational Services. Generally, the only clients referred directly to Fort Logan Mental Health Center are alcoholism clients, clients under court order and deaf clients. The deaf services program serves the total state, but priority is given to clients from the Denver metropolitan area. With this exception, Fort Logan Mental Health Center serves Denver and 21 other counties in the north central and northeastern sections of Colorado. Service area population is approximately 1,900,000. Thirteen community mental health centers and three mental health specialty clinics are located in the service area. Short

term, acute care for adults is provided in local communities whenever possible. However, the hospital does provide acute care for adult patients from the Arapahoe Mental Health Center Catchment Area, the Aurora Mental Health Center Catchment Area, Northeast Colorado and North Central Colorado, and on contract with some local centers.

One of the objectives of the 1980-1985 Colorado Mental Health Plan is to have established specialized treatment service for the violently mentally ill at Fort Logan by October 1, 1982.

Colorado State Hospital

Location: Pueblo

Total Staff: 1360.6 full time employee positions

Bed Capacity: 1113 licensed beds - all programs

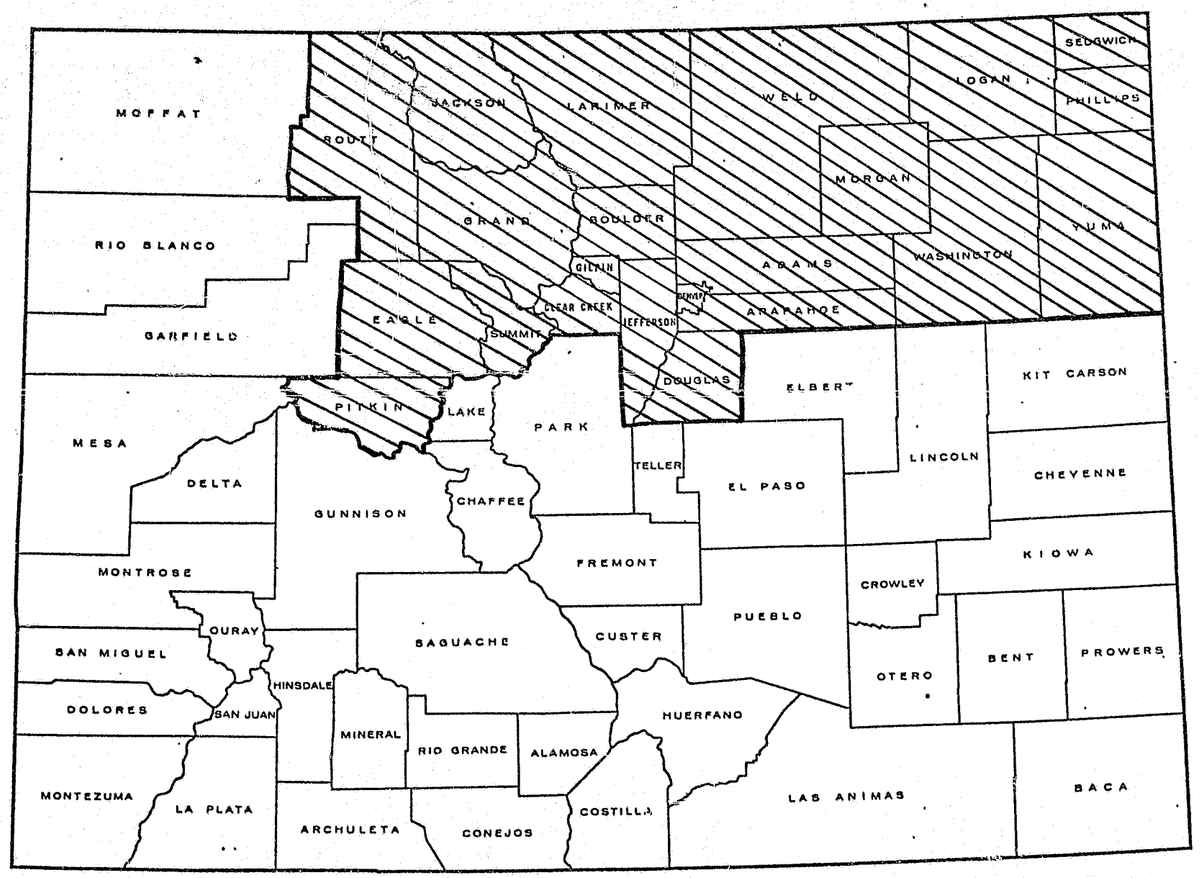
Total Operating Budget (FY1980-81): $29,130,160

Sources of Revenue:		
	General Fund	$18,005,447
	Cash funds, patient fees	7,208,043
	Cash funds, other state agencies	3,651,395
	Federal funds	265,277

Colorado State Hospital provides services in compliance with 27-13-101, C.R.S. 1973 et.seq., as amended. Colorado State Hospital program divisions include: Child and Adolescent Treatment Center, Geriatric Treatment Center, General Adult Psychiatric Services, Drug and Alcohol Treatment Center, Institute for Forensic Psychiatry, and General Hospital Services. The first three program divisions serve 41 counties of the southern and western portions of the state, with a total population of approximately 800,000 persons (see map on following page). The Drug and Alcohol Treatment Center, the Institute for Forensic Psychiatry, and the General Hospital Services serve all 63 counties of the state. The General Hospital also serves non-psychiatric residents of the other state institutions.

Colorado State Hospital has statutory responsibility for forensic clients. The Institute of Forensic Psychiatry receives forensic clients or the "criminally insane" who are committed by the court, transfers from correctional institutions, observation cases from the courts and civilly committed patients from the Fort Logan Mental Health Center or other areas of the Colorado State Hospital who temporarily need a specialized program with a secure environment. In addition, the Institute serves as a research and training center for those issues involved in the treatment of the criminally committed patient.

STATE HOSPITALS SERVICE AREA



Plain = Colorado State Hospital

Striped = Fort Logan Mental Health Center

Other Mental Health Treatment Resources

State

University of Colorado's University Hospital, located in Denver on the Health Sciences Center campus, serves as a resource for complex medical/psychiatric services throughout the state and also as a backup to many of the metropolitan Denver area health centers.

Private/Voluntary Treatment Resources

Four private psychiatric hospitals and over a score of private general hospitals which have psychiatric wards or which will accept psychiatric patients exist.

Mental health clinics and other non-hospital mental health treatment facilities which do not have contractual arrangements with the Department of Institutions are available resources.

Private practitioners (nurses, social workers, psychologists, pastoral counselors, psychiatrists, etc.) form a multitude of resources.

Other resources include the following:

1. volunteer agencies which provide treatment and/or personal counseling services. (These include Human Services Incorporated, Jewish Family and Children's Service, Catholic Community Services, and Lutheran Service Society);

2. other agencies whose functions include personal counseling (e.g., county departments of social services, probation and parole departments, vocational rehabilitation programs, community centers for the developmentally disabled, public health nurses);

3. sheltered workshops which provide such services as evaluation, work activity, short and long term work adjustment programs, sheltered employment, work stations in industry, and placement. Many of these workshops are geared specifically for psychiatric patients (e.g., Bayaud Industries, Bridge Industries, Adams County Work and Evaluation Center);

4. private organizations which do not fall into any of the above categories, but which are primarily oriented toward services to specific populations such as drug and alcohol abusers.

APPENDIX E

APPENDIX E

MENTAL HEALTH RESOURCES

The mental health resources available throughout the state are shown in the attached table. The table shows resources by the 13 planning regions of the state by type of services.

Mental health center services indicate the name of the center or centers in the region, the location of satellite offices and the type of services available. The data on the mental health centers is summarized from the Division of Mental Health State Plan. The second column shows the number and location of inpatient psychiatric beds. The drug and alcohol services shown in column three were provided by the Division of Alcohol and Drug Abuse.

The data on private sector services were obtained through a mail survey of 3,346 mental health professionals in the spring of 1980 and is reported in the Division of Mental Health Evaluation Report #27. The study was conducted by a Mental Health Association of Colorado task force. The figures represent a 420 percent response rate so the resources in this category are probably underestimated.

There is considerable difference in the level of service available in the various areas of the state. As expected more resources are available in urban areas than in rural areas.

Private sector practitioners tend to provide services to less severely impaired clients than mental health centers. The following table compares psychiatric impairment level between the private sector and mental health centers. Please note that these figures may not be strictly comparable.

Impairment Level	Private Sector	Mental Health Centers
Minimal	21.9%	19.1%
Mild	33.1%	
Moderate	33.2%	69.0%
Severe	11.8%	11.9%

In addition to the resources shown in the table the state is divided into two catchment areas for the two state hospitals. Fort Logan Mental Health Center services the northeast area of the state including the Denver metro area. The balance of the state is serviced by Colorado State Hospital in Pueblo.

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Regions 1 and 5	Centers • Centennial Mental Health Center Sterling Yuma Ft. Morgan Satellite Office Julesburg Holyoke Wray Akron	Services • Inpatient services through state hospitals and several local hospitals • Case management and residential planning in majority of locations • Day treatment • Vocational evaluation training and placement • Six section 8 units in Ft. Morgan • Multi-dimensional living complex in Sterling • Childrens and adolescents programs • Programs for the elderly • Substance abuse screening and evaluations	--	•Centennial M.H.C. - Outpatient Drug Free Services - Outpatient Alcohol Services	Psychiatrists - 0 Psychologists -- 0 Social Workers - 2 Other - 1
Region 2	Centers • Weld County Mental Health Center	Services • Inpatient at Weld County General Hospital • Childrens services • Extented care at Windsor • Programs for the elderly • Health Care (60 psychiatric beds) • Adult group home services at Krieger Boarding Home	• Psychiatric Units in General Hospitals: - Weld County Gen'l. Hospital (18 beds)	•Harmony Foundation (Estes Park) - 5 Nonhospital Detox Beds - 30 Inpatient Rehabilitation Beds - Outpatient Alcohol Treatment •Institute for Alcohol Awareness (Ft. Collins/Greeley) - Outpatient Alcohol Treatment •Larimer County Alcohol Services (Ft. Collins) - Outpatient Alcohol Treatment •House of Hope (Loveland) - Outpatient Alcohol Treatment	Psychiatrists - 5 Psychologists -10 Social Workers-12 Other -13

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 2 continued	Centers	Services			
	• Larimer Mental Health Center	• Inpatient • Outpatient • Partial Care • Transitional Care • Medical and Psychiatric • Crisis Intervention • Public education and consultation • Childrens Programs • Programs for Elderly • Pilot program with Ft. Logan to address needs of the combative, assaultive patient	• Psychiatric Units in General Hospitals: - Poudre Valley Memorial Hospital (9 beds)	• Larimer County M.H.C. (Ft. Collins) -Outpatient Drug Free Services • Alcohol Recovery Rehabilitation Center (Greeley) -15 Nonhospital Detox Beds -15 Inpatient Rehabilitation Beds -Outpatient Alcohol Treatment • Horizons (Greeley) -Outpatient Drug Free Services	Same as Weld County
Region 3	Centers	Services			
	• Adams County Mental Health Center Offices in: Commerce City Westminster Northglenn Brighton	• Outpatient • 24 Hr. Emergency • Inpatient • Other 24 Hr. Care • Partial Care at Commerce City • Hospital Care at Denver Metro Hospitals • Contractual Services for the chronically mentally ill with the Community Corp. through the Adams county Work & Eval. Center and Adams Pre-vocational and Life Adjustment Program • Childrens Program • Programs for Elderly	--	• Arapahoe House (Englewood/Aurora*) -24 Nonhospital Detox Beds -17 Inpatient Rehabilitation Beds -Outpatient alcohol services* • Aquarius (Englewood) -Outpatient Drug Free Services -Outpatient Alcohol Treatment • Alcohol Counseling Srvcs. of Colo. (Denver) -Alcohol Outpatient Treatment • Arvada/Longmont Counseling Center -Outpatient Alcohol Treatment • Attitude Development Services (Westminster/Lakewood) -Outpatient Alcohol Treatment	Psychiatrists - 0 Psychologists - 3 Social Workers - 2 Other - 0

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 3 Con't.	Centers	Services			
	• Arapahoe Mental Health Center, Inc.	• Outreach • Crisis • Outpatient • Partial Care • 24 Hr. Care • Childrens Programs • Programs for Elderly	--	• Auraria Community Center (Denver) -Outpatient Drug Free Services -Outpatient Alcohol Treatment • Aurora Center for Treatment (Aurora) -Outpatient Alcohol Treatment • Bellwood Educational Resources Center (Evergreen) -Outpatient Alcohol Treatment • Bethesda Hosp. Assoc. (Denver) -Outpatient Drug Free Services -Outpatient Alcohol Treatment • Boulder County Alcohol Recovery (Boulder) -7 Nonhospital Detox Beds -Outpatient Alcohol Treatment • Boulder M.H.C. (Boulder/Longmont) -Outpatient Drug Free Services • Boulder Psychiatric Institute(Boulder) -12 Inpatient Rehabilitation Beds • Broomfield Alcohol Awareness Family Health Center (Broomfield) -Outpatient Alcohol Treatment • Community Alcohol/Drug Rehabilitation Education Center (CADREC) (Denver) -Outpatient Alcohol Treatment • Center for Creative Living, Inc. (Lakewood) -24 Inpatient (alcohol) Rehabilitation Beds • Choices (Boulder) -Outpatient Alcohol Treatment • Cottonwood Hall, Inc. (Arvada) -24 Inpatient Alcohol Rehab. Beds • Denver Opportunity (Denver) - Alcohol OP Treatment	Psychiatrists - 12 Psychologists - 11 Social Workers - 13 Other - 5
	• Aurora Mental Health Center, Inc.	• Direct consultation and educational services • Intensive day treatment and followup care • Services to hospitalized clients, disposition planning, supervision of local short-term center residential facility staff and program and consultation to hospital personnel • Off hours emergency services provided by contracted employees • Childrens Programs • Programs for Elderly	• Private Psychiatric Specialty Hospital: Bethesda Hospital (70 beds)		Psychiatrists - 4 Psychologists - 5 Social Workers - 8 Other - 1
	• Bethesda Community Mental Health Center, Inc.	• Hospitalization • Hospital alternative program • Halfway house • Partial Care • Outpatient Care • Intake & Emergency • Program Evaluation • Consultation & Education			--

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 3 con't.	Centers	Services		• Empathy House (Boulder) -30 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Tratment • Inter-Tribal Heritage Project (Denver) -Outpatient Alcohol Treatment • Jefferson Co. Dept. of Health (Lakewood) -20 Nonhospital Detox Beds -Outpatient Alcohol Treatment • Joan Owen, Alcohol Behavior Information (Arvada) -Outpatient Alcohol Treatment • Denver C.A.R.E.S. (Denver) -60 Nonhospital Detox Beds -Outpatient Alcohol Treatment -22 Inpatient Rehab. Beds • Denver H & H, Substance Treatment Services (Denver) -Outpatient Methadone Maintenance -Outpatient Drug Free Services • Denver Opportunity (Denver) -Outpatient Alcohol Treatment • Lost and Found (Morrison) -13 Inpatient Alcohol Rehab. Beds • Midtown Center (Denver) -Outpatient Alcohol Treatment • Milestone Counseling Srvcs., Inc. (Denver) -Outpatient Alcohol Treatment • Multi-Services (Denver) -Outpatient Alcohol Treatment • Northside Empathy Center, Inc.(Denver) -39 Inpatient Alcohol Rehab. Beds	
	Bethesda Community, con't.	• Adult foster care program in conjunction with the halfway house • HUD housing for the chronically mentally disabled • Specialized program for chronic psychiatric patients • Doctoral level psychology intern training program • Other specialized services for women, late adolescents, young adults and vocationally disabled clients			
	• Mental Health Center of Boulder County, Inc.	• Inpatient • Partial Care in Boulder and Longmont • Outpatient care in Boulder, Longmont & Lafayette • Emergency • Followup After Care • Program Evaluation • Residential & Intensive treatment • Childrens Program • Program for Elderly • 24 Hr. Halfway House	• Private Psychiatric Specialty Hospitals: Boulder Psychiatric Institute (38 beds)		• Contracts with Boulder Psychiatric Institute for provision of adult inpatient psychiatric bedspace, nursing and associated services Psychiatrists - 16 Psychologists - 16 Social Workers - 17 Other - 4

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 3 con't.	Centers	Services			
	• Denver Mental Health Center, Inc.	• Individual psychotherapy program for children, adolescents, adults, elderly, targeted clients, ethnic minorities and women • Treatment service to people in community who are in the human services field, where stress is high • Special program is provided to the Park Avenue Baptist Nursing home which houses many elderly with chronic severe mental health problems • Staff provides supervision for mental health professionals who work in other agencies in the community, such as welfare	• Private Psychiatric Specialty Hospitals: Mount Airy Psychiatric Center (82 beds) • Psychiatric Units in General Hospitals: Childrens' Hospital (6 beds) Denver General Hosp. (30 beds) Porter Memorial Hosp.(31 beds) St. Anthony's Hosp. (19 beds) St. Joseph's Hosp. (39 beds) • Psychiatric Units in Federal Hospitals: Veterans Administration Hospital (76 beds) • State Operated Psychiatric Hospitals: University Psychiatric Hospital (40 beds)	• Personal Development Center (Wheat Ridge) -Day Care Drug Treatment Program -3 Residential Drug Treatment Beds -Outpatient Drug Free Services -12 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Porter Hospital's Alcohol Therapy Program (Denver) -Outpatient Alcohol Treatment • Raleigh Hills Hospital (Denver) -33 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Salvation Army Adult Rehab. Center (Denver) -35 Inpatient Alcohol Rehab. Beds • Servicios de La Raza (Denver) -Outpatient Alcohol Treatment • Sobriety House (Denver) -36 Inpatient Alcohol Rehab. Beds • Stepping Stone House Unlimited(Denver) -14 Inpatient Alcohol Rehab. Beds • S.W. Denver Comm. M.H.C. (Denver -Outpatient Alcohol Treatment • U of C Health Sciences Center(Denver) -Outpatient Drug Free Treatment • A.R.T.S. (Denver) -Outpatient Methadone Maintenance -Outpatient Drug Free Treatment • PEER I (Denver) -42 Residential Drug Program Beds • Self Center (Denver) -15 Residential Drug Program Beds -15 Inpatient Alcohol Rehab. Beds • Synergy (Denver) -26 Residential Drug Program Beds	
	• Health & Hospitals Mental Health Program	• Located in Denver General Hospital • Emergency Services • Inpatient • Outpatient • Partial Day Care • Rehabilitation • Halfway House Prog. • Childrens Services • Consultation & Ed. • Rape Victim Support Services			

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 3 con't.	Centers	Services	• Psychiatric Units in General Hospitals: Lutheran Medical Center(6 beds)	• Washington House (Commerce City) -31 Nonhospital Alcohol Detox Beds -Alcohol Outpatient Services • Washington House West (Thornton) -18 Inpatient Alcohol Rehab. Beds • Westland Medical Clinic (Lakewood) -Outpatient Alcohol Treatment Srvcs. • Whole Person Health Center (Boulder) -Outpatient Alcohol Treatment Srvcs.	Psychiatrists - 6 Psychologists - 14 Social Workers - 29 Other - 9
	• Jefferson County Mental Health Center, Inc.	• Centralized inpatient program using Ft. Logan for long-term placement and St. Anthonys and Colo. Psychiatric Hosp. for short term placements • Outpatient services are decentralized • Emergency Services • Partial Care • Other 24 Hr. Srvcs. • Specialized programs for the chronically mentally ill • Special rural clinical services in Clear Creek & Gilpin counties • Childrens Programs • Programs for Elderly			
	• Park East Comprehensive Community Mental Health Center, Inc.	• Inpatient Care • Day treatment • Outpatient Services • Emergency Services • Consultation & Ed. • Specialized Service provides care to children, adolescents, elderly, victims of rape, & victimized women			

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 3	Centers	Services			
con't.	• Servicios de La Raza	• Outpatient • Emergency • Consultation & Ed. services of a specialized nature to the Spanish speaking community of Denver • Noncatchmented program coordination with nearby catchment area programs is provided			
	• Southwest Denver Community Mental Health Services, Inc. Office in Barnum serves the needs of Spanish surnamed/Chicano clients	• Provides a full range of services • Serves as local demonstration site for the Colorado Community Support Project through a contract which treats the chronically disabled person, with the Div. of Mental Health & the Nat'l. Institute of Mental Health	• State Operated Psychiatric Hospital: Ft. Logan Mental Health Center (203 beds)		

MENTAL HEALTH RESOURCES

Mental Health Centers		Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 4 Centers	Services	• Private Psychiatric Specialty Hospital: Emory John Brady Hospital (100 beds) • Psychiatric Units in General Hospital: Penrose Hospital (12 beds) St. Francis Hospital (13 beds)	• The Ark, Inc. (Green Mtn. Falls) -19 Inpatient Alcohol Rehab. Beds • El Paso City/Co. Health Dept. (Colo.Spgs) -Outpatient Methadone Maintenance -Outpatient Drug Free Services • Hilltop Nursing Home (Cripple Creek) -10 Inpatient Alcohol Rehab. Beds • Institute for Alcohol Awareness(Colo. Springs) -Outpatient Alcohol Reatment • Penrose Comm. Hosp.(Colorado Springs) -6 Nonhospital Detox Beds -8 Inpatient Alcohol Rehab. Beds • Peterson AFB Drug/Alcohol Abuse Control (Colorado Springs) -Outpatient Alcohol Treatment Srvcs. • Alcohol Receiving Center(Colo. Spgs.) -20 Nonhospital Detox Beds • Comm.Intensive Residential Treatment Program (Colorado Springs) -20 Inpatient Alcohol Rehab. Beds • Halfway House (Colorado Springs) -5 Inpatient Alcohol Rehab. Beds • Outpatient Program (Colorado Springs) -Outpatient Alcohol Treatment • Park/Teller Co. Outpatient Satellite (Cripple Creek) -Outpatient Alcohol Treatment • Turning Point Institute (Colo.Spgs.) -Outpatient Alcohol Treatment • Uplift Awareness Center (Colo. Spgs.) -Outpatient Alcohol Treatment	Psychiatrists - 13 Psychologists - 11 Social Workers - 29 Other - 13
• Pikes Peak Mental Health Center	• Geographic Outpatient Services -Team 1 in Colorado Springs -Team 2 in Fountain, Colo. also provides rural services to Teller & Park counties -Team 3 is located in the fastest population growth area of Colo. Spgs. • CARES Crisis Intervention • Adult Day Treatment • Residential & Emergency Services Program • 24 Hr. Crisis Unit • Childrens Programs • Programs for Elderly			

Mental Health Centers		Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 6	• Southeastern Colorado Family Guidance & Mental Health Center 4 fulltime offices in Rocky Ford, La Junta, Las Animas & Lamar 4 part-time offices in Ordway, Eads, Walsh & Springfield • Childrens Team • High-risk Team operates two partial care programs in La Junta & Lamar • Adult Outpatient Team • Minority Services Team	• Psychiatric Units in Federal Hospitals: Fort Lyon Veterans Hospital (193 beds)	• RESADA (Las Animas) -5 Nonhospital Detox Beds -6 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Southeastern Tri-County Alcohol (Lamar) -Outpatient Alcohol Treatment	Psychiatrists - 0 Psychologists - 0 Social Workers - 2 Other - 0
Region 7	Centers • Spanish Peaks Mental Health Center -Huerfano Alcoholism & Mental Health Unit Services • 24 Hr. Emerg. & Crisis Services • Admission screening Services • After Care Services • Partial Care Srvcs. for adults • Outpatient treatment services for children, adolescents, adults and the elderly • Consultation & Ed. services • Childrens Progams • Programs for Elderly	• State Operated Psychiatric Hospital: Colorado State Hospital (706 beds) • Psychiatric Units in General Hospitals: Parkview Episcopal Hospital (31 beds) St. Mary Corwin Hospital (24 beds)	• Comprehensive Alcohol Treatment (Pueblo/Walsenburg/Trinidad) -Outpatient Alcohol Treatment • C.S.H., New Horizons (Pueblo) -40 Residential Drug Program beds • C.S.H., Plains Addiction Recovery Center (Puelbo) -Outpatient Methadone Maintenance -Outpatient Drug Free Treatment • C.S.H., The Circle (Pueblo) -25 Residential Drug Treatment Beds • Fisher's Peak (Trinidad) -10 Nonhospital Detox Beds -10 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Institute for Alcohol Awareness (Pueblo) -Outpatient Alcohol Treatment	Psychiatrists - 1 Psychologists - 6 Social Workers - 6 Other - 0

MENTAL HEALTH RESOURCES

Mental Health Centers			Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 7 con't.	-Las Animas Alcoholism and Mental Health Unit	• Pre-admission screening services • After Care Services • Partial Care Srvcs. for Adults • Outpatient Treatment Services for children, adolescents, adults and the elderly • Consultation & Ed.		• Our House (Pueblo) -20 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Pueblo Treatment Services (Pueblo) -15 Nonhospital Detox Beds - 5 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment	
	-Adult Partial Care Unit	• Provides short (2 hours) and long (4 hours) day treatment services			
	-Adult Out-patient Program	• 24 Hr. Emergency & Crisis Service • Pre-admission screening services			
	-Adult Out-Patient Program, continued	• After Care Services • Evaluation and development of treatment programs • Individual and group therapy • Law enforcement liaison			

MENTAL HEALTH RESOURCES

Mental Health Centers		Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 8				
• Transitional Care Residential Center Southeast Team Alamosa, Conejos, Costilla counties Northwest Team Rio Grande, Mineral and Saguache counties	• Helps people move from structured institutional setting to a less structured community setting • Used for temporary residential placement for patient crisis problems • Outpatient services • Partial Care Srvcs. • 24 Hr. Emergency/ Crisis Services on a walk-in/call-in basis • Consultation & Ed.	• Colorado State Hospital is available for both short-term and long-term hospitalization • Immediate and short-term hospitalization provided by: Alamosa Community, Monte Vista Community, St. Joseph and Conejos County Hospitals	• Professional Counseling Srvcs.(Alamosa) - Outpatient Alcohol Treatment • Detox Center (Alamosa) -8 Nonhospital Detox Beds • San Acacio Inpatient (San Acacio) -20 Inpatient Alcohol Rehab. Beds • San Luis Valley Comp.Comm. M.H.C. Outpatient (San Luis/La Jara/Monte Vista -Outpatient Alcohol Treatment	Psychiatrists - 1 Psychologists - 0 Social Workers - 1 Other - 0
Region 9				
• Southwest Colorado Mental Health Center 3 Outpatient centers at: Durango, Cortez & Pagosa Springs	• Outpatient Services • Emergency Services • After Care Services • Consultation & Ed. • Partial Care • Works in close affiliation with the Sheltering Oak Group home which is a long term, residential facility housing 14 chronically disabled mentally ill adults	• Secure holding room at Mercy Medical Center has provisional designation as a 72 hour hold facility	• Dr. Alfred Bedford(Durango) -Outpatient Methadone Maintenance • Human Potential Develop.Corp.(Cortez) -Outpatient Alcohol Treatment • Southern Ute Comm.Action Programs (Ignacio) -8 Nonhospital Detox Beds -16 Inpatient Rehab. Beds -Outpatient Alcohol Treatment • Durango Drug Project (Durango) -Outpatient Drug Free Treatment • Ute Mtn. Ute Tribe (Towac) -Outpatient Alcohol Treatment	Psychiatrists - 0 Psychologists - 2 Social Workers - 1 Other - 1

MENTAL HEALTH RESOURCES

Mental Health Centers		Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Region 10				
• Midwestern Colorado Mental Health Center Serves a six county, sparsely populated area involving some 20 communities	• Full range of comprehensive services to catchment area residents		• Midwestern Colo. M.H.C. (Montrose/Delta/Norwood/Gunnison) -Outpatient Alcohol Treatment	Psychiatrists - 0 Psychologists - 0 Social Workers - 1 Other - 1
Regions 11 and 12				
• Colorado West Regional Mental Health Center	• Emergency Services • Outpatient • Consultation & Ed. • Partial Care • Services to moderately and severely disabled adults including: -inpatient -halfway house -partial care -subsidized apartment units • Minority Service Team	• Psychiatrict Units in General Hospitals: St. Mary's Hospital (13 beds)	• Bridge House (Grand Junction) -8 Nonhospital Detox Beds -28 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • Mtn. Rivers Alcohol Receiving Center (Glenwood Springs) -4 Nonhospital Detox Beds -3 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment • OM Inst., Inc. (Grand Junction) -Outpatient Alcohol Treatment •Steven Landman, Family Therapist (Grand Junction) -Outpatient Alcohol Treatment • White River Counseling (Rifle) -Outpatient Alcohol Treatment • Alpine M.H. Clinic (Granby/Breckenridge /Aspen/Vail/Steamboat Spgs.) -Outpatient Drug Free Treatment -Outpatient Alcohol Treatment	Psychiatrists - 3 Psychologists - 7 Social Workers - 8 Other - 4

MENTAL HEALTH RESOURCES

Mental Health Centers	Inpatient Psychiatric Beds	Drug & Alcohol Services	Private Sector Services
Regions 11 and 12 con't.		• Northwest M.H. Clinic(Craig/Rangely) -Outpatient Drug Free Treatment -Outpatient Alcohol Treatment • Northwest Colo. Detox. & Residential Care Center (Craig) -5 Nonhospital Detox. Beds -15 Inpatient Alcohol Rehab. Beds -Outpatient Alcohol Treatment -Outpatient Drug Free Treatment • Sopris M.H.Clinic (Glenwood Springs/ Rifle) -Outpatient Alcohol Treatment -Outpatient Drug Free Treatment • N.W. Mental Health Srvcs. (Meeker) -Outpatient Alcohol Treatment -Outpatient Drug Free Treatment • High County Alcohol Ed. & Treatment Programs (Breckenridge) -Outpatient Alcohol Treatment	
Region 13 Centers • West Central Mental Health Center Serves Fremont, Chaffee, Lake and Custer counties Services • Screening Services • Inpatient Care • After Care Services • Partial Care Srvcs. • Transitional Care Services • Halfway Houses(use of private homes) • Outreach Services • Outpatient Services • Crisis Intervention	--	• Drug & Alcohol Abuse, Inc. (Canon City) -Outpatient Alcohol Treatment • Leadville Alcohol Program (Leadville) -Outpatient Alcohol Treatment	Psychiatrists - 1 Psychologists - 0 Social Workers - 1 Other - 0

APPENDIX F

M E M O R A N D U M ----------

TO: MEMBERS OF THE TASK FORCE ON THE DANGEROUS MENTALLY ILL

FROM: DR. DENNIS KLEINSASSER, CHAIR

SUBJECT: TASK FORCE REPORT

DATE: DECEMBER 21, 1981

Enclosed is a copy of the final draft of the task force report and recommendations. Most of the report has been distributed at various meetings. Please review and provide any comments to Mary Mande at the Division of Criminal Justice no later than January 8, 1982. If comments are not received by that date, the staff will go ahead and publish the report.

The final report will also include several appendices to include a bibliography, minutes of the meetings, case descriptions, resources and a description of mental health and criminal justice agencies which have responsibilities related to the dangerous mentally ill person. The minutes from the final meeting are enclosed for your review.

I would like to express my thanks and that of the staff for your hard work and enthusiasm in addressing the issues. We feel that the work of the task force will be of significant value to the state and that many of the recommendations will be implemented over the next several years.

The staff will pursue with the governor's office gaining authority for subgroups to continue their work in the areas of statute changes and information exchange. If there are any other followup activities you would like to pursue individually, and require staff assistance, please contact Pat Malak.

DK:PAM:lk

END