CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Colorado Department of Human Services
Priority Number:	1
Change Request Title:	Staff and Operating Funding for the New High Security Forensics Institute (HSFI) at the Colorado Mental Health Institute at Pueblo (CMHIP)

SELECT ONE (click on box):

☒ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☐ Supplemental Request FY 07-08
☐ Budget Request Amendment FY 08-09

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request:

Construction will be completed on the State's new state-of-the-art, 200-bed, 200,000 square-foot, High Security Forensic Institute (HSFI) in the Institute for Forensic Psychiatry (IFP) on the campus of the Colorado Mental Health Institute at Pueblo (CMHIP) in June 2009.

This request consists of two sections that total $1,402,553 General Fund and 11.6 FTE in FY 2008-09 and annualizes to $3,078,058 General Fund and 39.7 FTE in FY 2009-10. The Office of Behavioral Health and Housing (OBHH) Mental Health Institute (MHI) section (pages D-1-8 to D-1-126) is for staff and operating funds necessary to operate the new facility and the Office of Operations section (pages D-1-127 to D-1-135) is for new facility operating funds for the HSFI and the heat plant expansion at the CMHIP.

The summary of the MHI request is on pages D-1-25 to D-1-28 and the summary of the Office of Operations request is on page D-1-129.

Short Summary of Mental Health Institute Request:

This decision item is for $638,190 General Fund and 5.1 FTE in FY 2008-09, which annualizes to $1,737,615 General Fund and 22.7 FTE in FY 2009-10 to provide the remaining staff and operating funds necessary to operate the new HSFI.

Background and Appropriation History:

Description of the Institute of Forensic Psychiatry (IFP)

The Colorado Mental Health Institute at Pueblo is one of two publicly funded facilities responsible for providing inpatient hospitalization for mentally ill citizens of Colorado. The other is the Colorado Mental Health Institute at Fort Logan (CMHIFL), which does not have a forensic unit.

The Institute for Forensic Psychiatry (IFP) is a critical part of the Colorado public mental health system. It is a major division of the Colorado Mental Health Institute at Pueblo (CMHIP). Under sections 16-8-105 and 16-8-112, C.R.S., persons who are found to be Not Guilty by Reason of Insanity (NGRI) or Incompetent to Proceed (ITP) in criminal proceedings are committed to the Department of Human Services, which then determines the most appropriate facility for treatment. Additionally, section 16-8-106, C.R.S., specifically requires the Colorado Mental Health Institute at Pueblo to conduct psychiatric examinations ordered by the court in criminal cases. Historically, the CMHIP's Institute for Forensic Psychiatry (IFP) has been the entity designated to provide these services because it maintains adequate security to treat individuals accused of particularly violent crimes. It is the State's only forensic hospital, and serves as the primary treatment facility for adults with coexisting severe mental illness and criminal involvement.

HSFI Planning and *Neiberger* lawsuit

Planning for a new HSFI has been ongoing for almost a decade. Senate Bill 95-214 funded the development of a facilities master plan for the CMHIP campus. In 1999, the General Assembly and the Governor appropriated funding for the Department to develop a Facility Program Plan for the HSFI that aligned with the CMHIP master plan, and replaced 168 beds on the existing medium- and maximum-security units. This

square-foot High Security Forensic Institute and provided an additional 32 beds for the medium- and maximum-security forensics program.

The *Neiberger v. Schoenmakers* (*Neiberger*) lawsuit, which also began in 1999, was brought by a class of patients at the Institute for Forensic Psychiatry (IFP) who had been found by Colorado state courts to be Not Guilty by Reason of Insanity (NGRI) to criminal charges. The *Neiberger* plaintiff class claimed that the IFP physical plant was unsafe, that staffing levels did not meet constitutional minimums and that treatment and basic living conditions were constitutionally inadequate. Units in the IFP are located in old, outdated and inadequate facilities designed to house patients rather than treat their mental illness and reintegrate them into the community. In addition to the *Neiberger* lawsuit, the Department was sued in wrongful death litigation brought by the families of two of four patients who, within an 18-month period of time, committed suicide at CMHIP.

The *Neiberger* lawsuit was settled in 2002 after three years of litigation. The settlement agreement, which ended December 31, 2006, required (in part): mandatory staffing levels (a 1.35-to-1 staff-to-patient ratio and monitored efforts to maintain a 1.16 to 1 psychiatrist-to-patient ratio); caps and eventual reductions to the census for the maximum and medium security units; specific qualifications and training for staff; opportunities for each patient to be out of doors no less than 30 minutes each day; availability of certain equipment for patients; creation of the Forensic Community Based Services (FCBS) program (a transitional program for patients to move to a community setting); and court monitor reviews of appropriate patient progression to community settings. It also required that a new forensic facility, "remain the number one capital construction priority of the Department until the new facility is built."

In 2005, the General Assembly passed H.B. 05-1309, authorizing the Department to enter into a lease agreement for a new HSFI facility that would be built with private funds and then leased back to the state. House Bill 06-1373 repealed H.B. 05-1309 and authorized direct funding of $59.7 million from the State to build the facility and

modify auxiliary buildings. The timeline for building completion is provided in the table below.

Timetable for Forensics Replacement Facility
(Source: CMHIP – Forensics Replacement & Heat Plant Expansion, Phase IV of IV, page 4)

Phase	Start Date(s)	Completion Date(s)	Remarks
Physical Planning Phase	07/99	12/06	Includes Facility Program Plan, Design and Restart of the Project, completion of the Design
Demolition	06/06	01/07	Includes bidding for Building #108 demolition to prepare the site for general construction
Construction Phase	10/06	03/09	Includes bidding and new construction
Equipment Phase	12/08	04/09	Procurement and Installation
Commissioning and Testing	05/09	06/09	
Occupancy	07/09		

For FY 2007-08, the Department submitted a capital construction request for the HSFI that included an estimate for operating costs associated with operating an additional 32 beds. This estimate was a "straight line" projection based on then-current staffing levels and assumptions and did not include an estimate of the cost of providing improved active treatment programming for these medium- and maximum-security patients within the context of the new physical plant. For this request, the Department updated the FY 2007-08 operating estimate included in the capital construction request (see Attachment 1-Reference only) and identified the minimum necessary staffing levels for direct care and active therapeutic programming in the new facility (see Attachment 2-Detail of Department's request).

The Department broke ground for the HSFI in January 2007.

HSFI Operating Funding Already Approved

In December 2006, the Department received a supplemental/budget amendment appropriation of $3,456,502 and 49.1 FTE from the General Assembly to fund 20 of the

additional 32 beds associated with the HSFI to address a growing waiting list for court-ordered inpatient competency evaluations and restorations (A portion of this funding was appropriated to CMHIP and a portion was appropriated to the Office of Operations for the new 20-bed unit.).

Competency evaluations at CMHIP occur when the court orders that an individual be evaluated for their ability to stand trial for the crimes of which they are accused. The court may order the individual to undergo an "outpatient evaluation," which is generally conducted in a jail or rarely some other approved location; 80% of court-ordered evaluations are done outside of CMHIP (i.e., as an "outpatient evaluation"). Alternatively, the court may order that an "inpatient evaluation" be conducted at CMHIP because it is a sufficiently secure treatment setting. In either case, the individual must be able to understand the charges against them and participate in their own defense. If an individual cannot understand the charges against them or participate in their own defense, the individual is considered Incompetent to Proceed (ITP) and the court may order the individual to CMHIP to be "restored" to competency (i.e., competency restoration) to stand trial.

Over the past few years, the number of court-ordered sanity and competency evaluations and ITP restorations referred to the CMHIP Institute of Forensic Psychiatry has increased significantly. During that time, the Department took numerous actions to meet this increasing demand and reduce waiting lists for these services. However in the fall of 2006, the waiting list had grown from 30 individuals to 81 individuals waiting up to five months in jail to be admitted for an examination. The table below shows the increase in the demand for these services.

CMHIP Exams (e.g. sanity, competency, mental condition, etc.) and Incompetent to Proceed (ITP) Referrals (i.e. competency restorations) per Fiscal Year

FY	Exams				ITPs				% Increase from FY0001	
	In Pt.	Out Pt.	Total	% Increase	In Pt.	Out Pt.	Total	% Increase	Exams	ITPs
0001	234	181	415		86	0	86			
0102	168	262	430	3.6%	96	0	96	11.6%	3.6%	11.6%
0203	81	333	414	-3.7%	107	0	107	11.5%	-0.2%	24.4%
0304	90	415	505	22.0%	111	0	111	3.7%	21.7%	29.1%
0405	102	441	543	7.5%	136	0	136	22.5%	30.8%	58.1%
0506	191	629	820	51.0%	164	5	169	24.3%	97.6%	96.5%
0607	224	615	839	2.3%	228	17	245	45.0%	102.2%	184.9%

Source: CMHIP record of the number of referred inpatient exams and ITPs includes those awaiting admission..

In the fall of 2006, the Mental Health Institute Director of Hospital Services (CMHIP Superintendent) was served by the Denver District Court with a contempt of court citation regarding failure to admit a patient in a timely manner per court order. The cases of two additional jail inmates joined in these contempt proceedings. The contempt of court citation (*Zuniga* v. Department of Human Services) was resolved and a lawsuit was avoided when the Department requested and received an emergency supplemental/budget amendment appropriation from the General Assembly to open a 20-bed unit designated to serve this population and address the court's requirements. Currently, no jail inmate is waiting more than 28 days for admission to CMHIP, and CMHIP has generally been able to admit emergency cases within two to five days after the county jail staff ask for this assistance. As of October 2007, the waiting list for these services was down to 5 people waiting approximately 7.8 days in jail.

Of the total amount received for the 20-bed competency evaluation and restoration unit, $3,005,607 and 46.7 FTE will be staff and operating costs transferred to operate the new HSFI (see Table 1 below). The balance of the supplemental/budget amendment funding was provided for administrative support to assist with reporting to the courts

and for additional evaluations in order to rapidly reduce the competency evaluation and restoration waiting list to avoid adverse actions against the State by the courts.

Table 1: Portion of the Competency Evaluation and Restoration supplemental/budget amendment applied to MHI portion of HSFI funding request (The Office of Operations request associated with HSFI has been submitted separately.)

Description FY 2006-07 Supplemental/Budget Amendment	**FTE**	**Dollars**
Executive Director's Office (FTE benefits)	0.0	$364,890
Office of Operations	1.4	$72,180
Mental Health Institutes line item	47.7	$2,896,258
General Hospital line item	0.0	$123,174
Emergency Supplemental/Budget Amendment Appropriation FY 2006-07	**49.1**	**$3,456,502**
Administrative FTE provided to specifically reduce competency evaluation and restoration waiting list (includes benefits)	(1.0)	($37,219)
Report costs provided to specifically address competency evaluation and restoration waiting list	0.0	($334,588)
Office of Operations funding provided with competency evaluation and restoration request to open 20-bed unit (includes benefits)	(1.4)	($79,088)
Balance of funding from FY 2006-07 supplemental that will be applied to staff and operating for the new HSFI	**46.7**	**$3,005,607**

Source: FY 2006-07 Emergency Supplemental Request, "S-1-J 1331 20 bed Comp Unit."

General Description of Request:

The HSFI is a brand new, state-of-the-art facility that provides the opportunity for the Colorado public mental health system to employ the most current and effective treatment modalities for forensics patients. These new opportunities for active treatment, give these patients the best opportunity to learn how to manage their mental illness (e.g. staying on medications, recognizing and eliminating negative behaviors), to function independently (e.g. receive life and vocational skills training) and to be successfully and safely reintegrated back into society.

Governor Ritter's *Colorado Promise* recognizes that medication and treatment of the state's mentally ill are essential to these individuals' abilities to live independently and reduce their usage of more costly public systems, such as returning to a mental health institute, prison or unnecessary use of emergency rooms. This cutting edge facility

allows the Department to provide these services in a secure setting that maximizes safety for the public, staff and patients while minimizing many of the risks of the old facility, such as patient escapes, patient assaults on staff and patient suicides.

The simplest description of the new HSFI is that it expands the State's bed capacity for medium- and maximum- security forensics patients by 32 beds. However, this description does not adequately reflect the full functionality of the building and its impact on the mental health system in Colorado (See Attachment 3 for layout and populations designated for the HSFI). The HSFI includes a number of specialized units such as: 1) a combination psychiatric/skilled-nursing unit for physically debilitated forensic patients (such as those that do not need medical hospitalization, but do require portable oxygen, walkers, specialized nursing care, and other resources not appropriate on, or safe for, regular forensic psychiatric units); 2) a specialized unit for patients with co-occurring developmental disabilities and mental illness so they can receive treatment modified to address the unique characteristics of developmental disabilities; 3) a specialized unit for competency evaluation and restoration patients, which will allows the State to continue to meet the terms of the *Zuniga* settlement agreement by establishing an onsite court room to streamline and expedite patient competency and other hearings; 4) a unit for female patients; and 5) a unit for prisoners from the Department of Corrections in need of specialized intensive mental health stabilization. The new facility also provides a patient-care clinic; a pharmacy; additional security features; and expanded treatment space and resources, including a new patient learning center (with a library, computers and learning software) — all housed within the same building and a secure perimeter.

These increases in capacity, security, medical care and psychiatric treatment capabilities will resolve all of the problematic issues with the existing physical facilities that were the basis of the *Neiberger* lawsuit, such as the following:

- Safety and Security-
    - Long narrow corridors leave patients out of the sight of staff posing greater suicide risks and greater difficulty for overall management of patients.

- False ceilings allow for patients to hide contraband (e.g. sharp objects, narcotics) and present suicide hazards.
- Units currently have insufficient space to segregate disruptive patients or patients that do not get along. Without sufficient space, feuding patients agitate each other and others on the ward, also inhibiting patient treatment/progression.
- Difficulty for staff supporting each other and providing assistance between units due to layout of the building.
- Limited opportunities for patient progression to less restrictive settings due to inadequate recreation and treatment space on the maximum- and medium-security units.
- Maximum and medium units are spread out, creating multiple challenges for staff transporting patients to other buildings for treatment, required recreation, court hearings, medical care etc. Any transport of forensics patients increases the risk of a security breach or an adverse patient episode, which is why the HSFI is designed to address most patients' needs in one building, thus minimizing the need for transport.

- Layout of Maximum- and Medium-Security Facilities
  - Separate maximum and medium facilities force staff to make decisions about patient progress based on unit capacity rather than patient readiness to progress and treatment needs. [This lengthens the average length of stay for these patients, thereby increasing the cost per patient served in the IFP.]
  - Existing facilities lack appropriate space for treatment because they were constructed at a time when the emphasis for psychiatric hospitals was on housing individuals rather than treating and progressing patients to the community. There are an extremely limited number of treatment rooms for group and individual therapies and limited recreation space (e.g. access to the outdoors).
  - Maximum and medium facilities have different amenities, such as single patient rooms on maximum-security and multiple occupancy rooms on

medium-security. Patients on medium-security sometimes act out in order to be placed back on maximum-security in a single occupancy room.

- The maximum and medium units are between 25 and 60 years old. They are inefficient to operate, wasteful of energy and problematic in terms of safety and clinical standards. Most units require electrical, plumbing and mechanical maintenance on systems that are obsolete. In addition, many units would require major renovations given the current treatment standards for the mentally ill and to bring these facilities up to current Americans with Disabilities Act (ADA) standards (e.g. the size of patient rooms does not meet the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) living codes, resulting in the Institute's need to operate under a waiver.).
- Maximum-security, in particular, is in very close proximity to Department of Corrections facilities on the CMHIP campus, which negatively influences perceptions by patients, family members and the community.

These factors lead to unsafe and inadequate treatment environments for patients and staff, which frequently extends the average length of stay for forensic patients. Longer lengths of stay increase the average cost per patient served by the IFP since the fixed costs of the IFP are spread over fewer patients (i.e. fewer patients are treated). The new facility addresses these issues through the combination of specialized units, a "Treatment Mall" with multiple therapeutic rooms for individual and group therapies and skills training, and recreation areas including access to the outdoors, available to each ward.

The funding request detailed in Attachment 2: Table 1 (below) includes:

a) Funding for 5.1 permanent FTE in FY 2008-09 and 22.7 permanent FTE in FY 2009-10 to provide the minimum necessary direct care staffing at the court-approved 1.35-to-1 staff-to-patient ratio for the additional 12 beds (32 beds less the 20 beds funded in the supplemental/budget amendment) and staffing to support the

new HSFI security, medical and treatment configuration (Attachment 2: Tables 2, 3, 4 & 5);

b) Operating funds for the additional 12 patients (including pharmaceuticals) and the additional FTE, as well as $10,000 to contract with DOC to help move into and set up the new facility (Attachment 2: Table 11 & 12);

c) One-time funding for library furnishings, moving expenses and start-up equipment for the skilled nursing unit (Attachment 2: Tables 13 & 14);

d) One-time funding in FY 2008-09 for the initial start-up, operating and personnel costs, including 4.1 short-term temporary FTE (Attachment 2: Table 7; FTE authority *not* requested) to cover training for direct care staff and unit transitioning. Using estimates provided by the Division of Youth Corrections for transition into a new youth facility, Sol Vista, the Department has estimated six months of transition time for existing and new staff associated with the HSFI, including transitioning patients to the new facility once it opens. The new facility will have state-of-the-art security systems, a treatment mall and new dining areas requiring staff to be trained in the operations of this new equipment as well as managing patient movement through all areas of the new facility.

e) One-time funding for 0.8 short-term temporary FTE (Attachment 2: Table 6; FTE authority *not* requested) in FY 2008-09 for the temporary operation of three dining areas while patents are transitioned to the new facility. Two existing dining areas will be collapsed into a new single dining area, but all three will be operational while patients on the units move from the old facilities into the HSFI over the course of four weeks;

f) One-time funding and 0.6 short-term temporary FTE (Attachment 2: Table 8; FTE authority *not* requested) in FY 2008-09 for the temporary operation of three security control posts, including the HSFI Central Control Station, until all patients are transferred to the HSFI; and

g) Medical costs for the General Hospital and "outside medical" costs (i.e. acute medical care provided by external medical providers) associated with the addition of 32 beds/patients (Attachment 2: Tables 9 & 10).

ATTACHMENT 2 - TABLE 1: Summary by Long Bill Section and Line Item **LONG BILL SECTION**	**FTE**	**FY 2008-09**	**FTE**	**FY 2009-10**
(1) Executive Director's Office				
(A) General Administration				
Health, Life & Dental	0.0	$ 0	0.0	$ 116,818
Short-term Disability	0.0	$ 0	0.0	$ 1,376
Amortization Equalization Disbursement (AED)	0.0	$ 6,832	0.0	$ 16,930
Supplemental Amortization Equalization Disbursement (SAED)	0.0	$ 3,201	0.0	$ 5,290
Shift Differential	0.0	$ 19,773	0.0	$ 35,345
SUB-TOTAL Executive Director's Office	**0.0**	**$ 29,806**	**0.0**	**$ 175,759**
(8) Mental Health and Alcohol and Drug Abuse Services				
(C) Mental Health Institutes				
PERSONAL SERVICES (Info. only)				
Staffing per Updated FY 08 Capital Construction Operating Est. (Tables 2 & 3)	3.2	$ 216,125	12.7	$ 864,508
Additional Therapeutic and Security Staffing (Tables 4 & 5)	1.9	$ 98,769	10.0	$ 468,811
One-Time Personal Services Transition Costs for Startup (Tables 6, 7 & 8)	0.0	$ 215,419	0.0	$ 0
Contractual PS Outside Medical Costs (Table 10)	0.0	$ 0	0.0	$ 79,981
Prior Year Supplemental Amortization Equalization Disbursement (SAED)	0.0	$ 0	0.0	$ 1,859
SUBTOTAL MHI Personal Services	**5.1**	**$ 530,313**	**22.7**	**$ 1,415,159**
OPERATING (Info. only)				
One-time and On-Going Library/Minor Furnishings (Table 13)	0.0	$ 26,650	0.0	$ 6,500
One-time moving costs (Table 11)	0.0	$ 10,000	0.0	$ 0
One-time FTE Operating Costs (Table 11)	0.0	$ 27,060	0.0	$ 0
On-Going Staff Operating (Table 11)	0.0	$ 0	0.0	$ 65,930
Pharmaceuticals (Table 12)	0.0	$ 0	0.0	$ 40,949
On-Going Patient Operating (Table 11)	0.0	$ 0	0.0	$ 62,021
Skilled Nursing Unit Capital Outlay/Operating (Table 14)	0.0	$ 14,361	0.0	$ 798
SUBTOTAL MHI Operating		**$ 78,071**	**0.0**	**$ 176,198**
SUBTOTAL Mental Health Institute Line Item	**5.1**	**$ 608,384**	**22.7**	**$ 1,591,357**

ATTACHMENT 2 - TABLE 1: Summary by Long Bill Section and Line Item	FTE	FY 2008-09	FTE	FY 2009-10
LONG BILL SECTION				
GENERAL HOSPITAL Line Item				
GH costs for additional 12 beds/patients (Table 9)	**0.0**	**$ 0**	**0.0**	**$ (29,501)**
SUBTOTAL Mental Health Institutes	**5.1**	**$ 608,384**	**22.7**	**$ 1,561,856**
TOTAL Request by Long Bill Line Item	**5.1**	**$ 638,190**	**22.7**	**$ 1,737,615**

Requested funds will provide active treatment for forensics patients at levels that were rarely available to these patients in the old facility. The opportunity to provide comprehensive treatment, through individualized treatment plans that focus on the safe progression of these patients to the community, has the potential to reduce lengths of stay, which results in individuals being served more efficiently and effectively at a reduced cost per patient for the state.

In summary, the request provides adequate educational materials for the library; oxygen and suction equipment to the skilled-nursing unit; security staffing for the larger perimeter and new admitting area; nurses, doctors and therapists for direct-care treatment; a team leader and support staff for the additional unit (the new facility will have nine units compared to the existing eight); funding for temporary staff to cover for permanent staff receiving training; funding for start up and moving support; and operating funds necessary for the care for 12 additional patients. These expenses are estimated to be the costs necessary to transition into the new facility and for the HSFI to become fully operational. This request will allow for initial hiring and start-up expenditures to begin in January 2009 with the admission and transfer of patients starting in June 2009. Transition costs were developed after consulting with the Division of Youth Corrections regarding the opening of their new facility, Sol Vista, on the CMHIP campus.

Consequences if Not Funded:

If not fully funded, the Department will transfer staff from existing maximum- and medium-security units to the degree that safety and security of the patients and staff is not compromised. The Department will hold down census (i.e. not admit new patients) in the facility as needed to provide a safe environment, leaving beds or units vacant as necessary. Treatment options also will be kept to a level that maintains safety and security. These actions will result in limited mobility of patients to therapeutic, recreational and vocational activities, and will not fully utilize the treatment capacity and potential of the new facility.

The *Neiberger* lawsuit restricted operations on medium- and maximum-security by requiring the Department to hold down the census on those units. With the opening of the new HSFI, the Department will be able to operate at full capacity due to the treatment and progression programs that will be available in the new facility. If the HSFI cannot operate at full capacity, with treatment and recreational opportunities fully in place, the State will risk legal action.

Calculations for Request:

SUMMARY OF CALCULATIONS				
Calculation of Changes to Original Capital Operating Estimate			**FTE**	**Dollars**
FY 2007-08 CMHIP - Forensics Replacement & Heat Plant Expansion, Phase IV of IV (Attachment 3: pg 4-12)			59.4	$ 3,420,603
Inflationary Adjustments (See Attachment 1)			0.0	$ 690,950
FY 2007-08 Capital Construction Operating for 32 beds Updated for FY 2008-09 (Attachment 1)			59.4	$ 4,111,553
FY 2006-07 Emergency Supplemental for 20-bed Competency Evaluation & Restoration Unit			(46.7)	$ (3,005,608)
Remaining Funds Based on FY 08 Capital Operating Estimate			12.7	$ 1,105,945
FY 2009-10 portion of request associated with the balance of the FY 2007-08 Cap. Constr. operating estimate			12.7	$ 1,034,908
FY 2009-10 portion of request associated with Additional FTE and Operating Need			10.0	$ 702,707
Total FY 2009-10 Request			22.7	$ 1,737,615
Amount Requested above FY 2007-08 Cap. Construction Operating Estimate			10.0	$ 631,670

SUMMARY OF CALCULATIONS			FTE	Dollars
Calculation of Changes to Original Capital Operating Estimate				
Total FY 2007-08 Cap. Constr. Operating Estimate Updated for Inflation			59.4	$ 4,111,553
Revised Minimum Necessary Operating Estimate- Annualized (FY 2009-10) Budget Request			69.4	$ 4,743,223
Difference Over FY 2007-08 Cap. Construction Operating Estimate			10.0	$ 631,670

SUMMARY OF REQUEST	FTE	FY 2008-09	FTE	FY 2009-10
		General Fund		General Fund
Portion of Request Based on FY 2007-08 Capital Construction Operating Estimate.				
(8) Mental Health and Alcohol and Drug Abuse Services				
(C) Mental Health Institutes				
Mental Health Institutes line item				
Personal Services Funding for 12.7 FTE for 12 beds	3.2	$ 216,125	12.7	$ 864,508
Library/Minor Furnishings	0.0	$ 26,650	0.0	$ 6,500
On-Going Staff Operating	0.0	$ 0	0.0	$ 60,930
One-Time FTE Operating Costs	0.0	$ 27,060	0.0	$ 0
On-Going Patient Operating	0.0	$ 0	0.0	$ 62,021
Pharmaceuticals	0.0	$ 0	0.0	$ 40,949
SUB-TOTAL Original Operating Estimate Portion of Request	**3.2**	**$ 269,835**	**12.7**	**$ 1,034,908**

Additional Funding Request	FTE	FY 2008-09	FTE	FY 2009-10
		General Fund		General Fund
(1) Executive Director's Office				
Health, Life & Dental	0.0	$ 0	0.0	$ 116,818
Short-term Disability	0.0	$ 0	0.0	$ 1,376
Amortization Equalization Disbursement (AED)	0.0	$ 6,832	0.0	$ 16,930
Supplemental Amortization Equalization Disbursement (SAED)	0.0	$ 3,201	0.0	$ 5,290
Shift Differential	0.0	$ 19,773	0.0	$ 35,345
Sub-Total EDO	0.0	**$ 29,806**	**0.0**	**$ 175,759**

SUMMARY OF REQUEST	FTE	FY 2008-09 General Fund	FTE	FY 2009-10 General Fund
(8) Mental Health and Alcohol and Drug Abuse Services				
(C) Mental Health Institutes				
Mental Health Institutes Line Item				
Additional Therapeutic and Security Staffing	1.9	$ 98,769	10.0	$ 468,811
One-Time Personal Services Transition Costs for Startup	0.0	$ 215,419	0.0	$ 0
On-Going Operating for Additional FTE	0.0	$ 0	0.0	$ 5,000
Skilled Nursing Unit Capital Outlay/Operating	0.0	$ 14,361	0.0	$ 798
One-time moving costs	0.0	$ 10,000	0.0	$ 0
Prior Year SAED	0.0	$ 0	0.0	$ 1,859
Costs for Outside Medical Care for Additional 32 Patients	0.0	$ 0	0.0	$ 79,981
Sub-Total MHI Line Item	**1.9**	**$ 338,549**	**10.0**	**$ 556,449**
General Hospital Line Item				
General Hospital Costs for an Additional 12 Patients	0.00	$ 0	0.0	$ (29,501)
Sub-Total General Hospital Line Item	**0.0**	**$ 0**	**0.0**	**$ (29,501)**
Sub-Total Additional Request (C) Mental Health Institutes	**1.9**	**$ 338,549**	**10.0**	**$ 526,948**
Sub-Total Additional Funding Request	**1.9**	**$ 368,356**	**10.0**	**$ 702,707**
TOTAL REQUEST All Sections	**5.1**	**$ 638,190**	**22.7**	**$ 1,737,615**

SUMMARY OF REQUEST	FTE	FY 2008-09 General Fund	FTE	FY 2009-10 General Fund
Portion of Request Based on FY 2007-08 Capital Construction Operating Est.				
(8) Mental Health and Alcohol and Drug Abuse Services				
(C) Mental Health Institutes				
Mental Health Institutes line item				
Personal Services Funding for 12.7 FTE for 12 beds	3.2	$ 216,127	12.7	$ 864,508
Library/Minor Furnishings	0.0	$ 26,650	0.0	$ 6,500
On-Going Staff Operating	0.0	$ 0	0.0	$ 16,565
One-Time FTE Operating Costs	0.0	$ 27,698	0.0	$ 0
On-Going Patient Operating	0.0	$ 0	0.0	$ 62,021
Pharmaceuticals	0.0	$ 0	0.0	$ 40,949
SUB-TOTAL Original Operating Estimate Portion of Request	**3.2**	**$ 270,475**	**12.7**	**$ 990,543**

Additional Funding Request	FTE	FY 2008-09 General Fund	FTE	FY 2009-10 General Fund
(1) Executive Director's Office				
Health, Life & Dental	0.0	$ 0	0.0	$ 80,874
Short-term Disability	0.0	$ 0	0.0	$ 1,375
Amortization Equalization Disbursement (AED)	0.0	$ 3,968	0.0	$ 16,930
Supplemental Amortization Equalization Disbursement (SAED)	0.0	$ 985	0.0	$ 5,291
Shift Differential	0.0	$ 6,484	0.0	$ 35,345
Sub-Total EDO	**0.0**	**$ 11,437**	**0.0**	**$ 139,815**

SUMMARY OF REQUEST	FTE	FY 2008-09 General Fund	FTE	FY 2009-10 General Fund
(8) Mental Health and Alcohol and Drug Abuse Services				
(C) Mental Health Institutes				
Mental Health Institutes Line Item				
Additional Therapeutic and Security Staffing	1.9	$ 98,769	10.0	$ 468,811
One-Time Personal Services Transition Costs for Startup	0.0	$ 215,419	0.0	$ 0
On-Going Operating for Additional FTE	0.0	$ 0	0.0	$ 5,000
Skilled Nursing Unit Capital Outlay/Operating	0.0	$ 14,361	0.0	$ 798
One-time moving costs	0.0	$ 10,000	0.0	$ 0
Costs for Outside Medical Care for Additional 32 Patients	0.0	$ 0	0.0	$ 79,981
Sub-Total MHI Line Item	**1.9**	**$ 338,549**	**10.0**	**$ 554,590**
General Hospital Line Item				
General Hospital Costs for an Additional 12 Patients	0.0	$ 0	0.0	$ (29,501)
Sub-Total General Hospital Line Item	**0.0**	**$ 0**	**0.0**	**$ (29,501)**
Sub-Total Additional Request (C) Mental Health Institutes	**1.9**	**$ 338,549**	**10.0**	**$ 525,089**
Sub-Total Additional Funding Request	**1.9**	**$ 349,986**	**10.0**	**$ 664,904**
TOTAL REQUEST All Sections	**5.1**	**$ 620,461**	**22.7**	**$ 1,655,447**

Summary of Request FY 2008-09	Total	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
LONG BILL SECTION					
(1) Executive Director's Office					
(A) General Administration					
Health, Life & Dental	$ 0	$ 0	$ 0	$ 0	$ 0
Short-term Disability	$ 0	$ 0	$ 0	$ 0	$ 0
Amortization Equalization Disbursement (AED)	$ 6,832	$ 6,832	$ 0	$ 0	$ 0
Supplemental Amortization Equalization Disbursement (SAED)	$ 3,201	$ 3,201	$ 0	$ 0	$ 0
Shift Differential	$ 19,773	$ 19,773	$ 0	$ 0	$ 0
SUB-TOTAL Executive Director's Office	$ 29,806	$ 29,806	$ 0	$ 0	$ 0
(8) Mental Health and Alcohol and Drug Abuse Services					
(C) Mental Health Institutes					
PERSONAL SERVICES (Info. only)					
Staffing per Updated FY 08 Capital Construction Operating Est. (Tables 2 & 3)	$ 216,125	$ 216,125	$ 0	$ 0	$ 0
Additional Therapeutic and Security Staffing (Tables 4 & 5)	$ 98,769	$ 98,769	$ 0	$ 0	$ 0
One-Time Personal Services Transition Costs for Startup (Tables 6, 7 & 8)	$ 215,419	$ 215,419	$ 0	$ 0	$ 0
Prior Year Supplemental Amortization Equalization Disbursement (SAED)	$ 0	$ 0	$ 0	$ 0	$ 0
Contractual PS Outside Medical Costs (Table 10)	$ 0	$ 0	$ 0	$ 0	$ 0
SUBTOTAL MHI Personal Services	$ 530,313	$ 530,313	$ 0	$ 0	$ 0

Summary of Request FY 2008-09	Total	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
OPERATING (Info. only)					
One-time and On-Going Library/Minor Furnishings (Table 13)	$ 26,650	$ 26,650	$ 0	$ 0	$ 0
One-time moving costs (Table 11)	$ 10,000	$ 10,000	$ 0	$ 0	$ 0
One-time FTE Operating Costs (Table 11)	$ 27,060	$ 27,060	$ 0	$ 0	$ 0
Staff Operating (Table 11)	$ 0	$ 0	$ 0	$ 0	$ 0
Pharmaceuticals (Table 12)	$ 0	$ 0	$ 0	$ 0	$ 0
Patient Operating (Table 11)	$ 0	$ 0	$ 0	$ 0	$ 0
Skilled Nursing Unit Capital Outlay/Operating (Table 14)	$ 14,361	$ 14,361	$ 0	$ 0	$ 0
SUBTOTAL MHI Operating	$ 78,071	$ 78,071	$ 0	$ 0	$ 0
SUBTOTAL Mental Health Institute Line Item	$ 608,384	$ 608,384	$ 0	$ 0	$ 0
GENERAL HOSPITAL Line Item					
GH costs for additional 12 beds/patients (Table 9)	$ 0	$ 0	$ 0	$ 0	$ 0
SUBTOTAL Mental Health Institutes	$ 608,384	$ 608,384	$ 0	$ 0	$ 0
TOTAL Request FY 2008-09	$ 638,190	$ 638,190	$ 0	$ 0	$ 0

Summary of Request FY 09-10	Total	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
LONG BILL SECTION					
(1) Executive Director's Office					
(A) General Administration					
Health, Life & Dental	$ 116,818	$ 116,818	$ 0	$ 0	$ 0
Short-term Disability	$ 1,376	$ 1,376	$ 0	$ 0	$ 0
Amortization Equalization Disbursement (AED)	$ 16,930	$ 16,930	$ 0	$ 0	$ 0
Supplemental Amortization Equalization Disbursement (SAED)	$ 5,290	$ 5,290	$ 0	$ 0	$ 0
Shift Differential	$ 35,345	$ 35,345	$ 0	$ 0	$ 0
SUB-TOTAL Executive Director's Office	$ 175,759	$ 175,759	$ 0	$ 0	$ 0
(8) Mental Health and Alcohol and Drug Abuse Services					
(C) Mental Health Institutes					
PERSONAL SERVICES					
Staffing per Updated FY 08 Capital Construction Operating Est. (Tables 2 & 3)	$ 864,508	$ 864,508	$ 0	$ 0	$ 0
Additional Therapeutic and Security Staffing (Tables 4 & 5)	$ 468,811	$ 468,811	$ 0	$ 0	$ 0
One-Time Personal Services Transition Costs for Startup (Tables 6, 7 & 8)	$ 0	$ 0	$ 0	$ 0	$ 0
Prior Year Supplemental Amortization Equalization Disbursement (SAED)	$ 1,859	$ 1,859	$ 0	$ 0	$ 0
Contractual PS Outside Medical Costs (Table 10)	$ 79,981	$ 79,981	$ 0	$ 0	$ 0
SUBTOTAL MHI Personal Services	$1,415,159	$1,415,159	$ 0	$ 0	$ 0

	Total	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
OPERATING EXPENSES					
One-time and On-Going Library/Minor Furnishings (Table 13)	$ 6,500	$ 6,500	$ 0	$ 0	$ 0
One-time moving costs (Table 11)	$ 0	$ 0	$ 0	$ 0	$ 0
One-time FTE Operating Costs (Table 11)	$ 0	$ 0	$ 0	$ 0	$ 0
Staff Operating (Table 11)	$ 65,930	$ 65,930	$ 0	$ 0	$ 0
Pharmaceuticals (Table 12)	$ 40,949	$ 40,949	$ 0	$ 0	$ 0
Patient Operating (Table 11)	$ 62,021	$ 62,021	$ 0	$ 0	$ 0
Skilled Nursing Unit Capital Outlay/Operating (Table 14)	$ 798	$ 798	$ 0	$ 0	$ 0
SUBTOTAL MHI Operating	$ 176,198	$ 176,198	$ 0	$ 0	$ 0
SUBTOTAL Mental Health Institute Line Item	$1,591,357	$1,591,357	$ 0	$ 0	$ 0
GENERAL HOSPITAL Line Item					
GH costs for additional 12 beds/patients (Table 9)	$ (29,501)	$ (29,501)	$ 0	$ 0	$ 0
SUBTOTAL Mental Health Institutes	$1,561,856	$1,561,856	$ 0	$ 0	$ 0
TOTAL Request FY 2009-10	$1,737,615	$1,737,615	$ 0	$ 0	$ 0

Assumptions for Calculations:

This change request includes two components: 1) a portion associated with the updated FY 2007-08 operating estimate included in the final capital construction submission for the HSFI (Attachments 1 & 4: *FY 2007-08 CMHIP - Forensics Replacement & Heat Plant Expansion, Phase IV of IV, pg 4-12*), totaling 3.2 FTE and $269,835, which annualizes to 12.7 FTE and $1,034,908 General Fund (not including benefits) in FY 2009-10; and 2) an additional 1.9 FTE and $338,549 in FY 2008-09, which annualizes to $526,948 (not including benefits) for 10.0 FTE in FY 2009-10, associated with additional security and therapeutic FTE needed to fully utilize this new facility.

Request Component #1: Updated Capital Construction Estimate

The original operating estimate included in the FY 2007-08 HSFI capital construction request used a conservative methodology to estimate the operating needs of the new facility. Since the new HSFI is going to increase the bed capacity on the IFP's medium- and maximum-security units by 32 beds, the operating estimate provided direct care and support staff for these additional beds, assuming a 1.35-to-1 staff-to-patient ratio, as was required by the *Neiberger* settlement agreement. This methodology was intentionally conservative for a number of reasons, including the fact that the State was managing a significant revenue shortfall between the years 2001 and 2004, which severely limited the size and scope of operating requests and halted capital construction projects that had not broken ground.

Attachment 1, which is provided for reference, outlines the itemized detail of how the FY 2007-08 HSFI capital construction operating estimate (using the 32-bed methodology) was updated for FY 2009-10. Attachment 1 shows the following:

1) All salaries were updated to reflect July 1, 2008 salaries;
2) A 19% increase was applied to competitive (nursing and direct care) positions;
3) FY 2007-08 common policy was applied for FTE operating, computer and LAN (Local Area Network) costs;
4) Other operating items that are calculated on a cost per patient day (e.g. pharmaceuticals) were updated using per patient day costs from the *FY 2005-06 Medicare Cost Report* and then inflated by a conservative growth factor of 2% per year through FY 2009-10; and
5) A 2% inflationary factor was applied to update other operating items included in the FY 2007-08 capital construction estimate, such as equipment and furnishings.

In addition, 2.0 FTE were reflected incorrectly for psychiatrists, because psychiatrists are contract staff and do not require FTE authorization. Given the Department's identified FTE need, these two positions (FTE) have been incorporated into the Department's request.

Request Component #2: Additional Security and Therapeutic Staffing

The 32-bed methodology for calculating the operating needs of the new HSFI was very conservative and did not address the new and greatly expanded treatment capabilities of the HSFI. Because the Department did not update operating estimates submitted in prior years, the Department is requesting the minimum staffing level necessary to operate the 200-bed facility. However, the Department has provided a table below identifying the highly preferable staffing level for the new facility that would make significantly better use of therapeutic opportunities.

TABLE 3: Staffing Scenarios	Optimal Staffing	Intermediate Staffing	Minimum Necessary (Request)
Direct Care Nursing Shift I			
Mid-Level Provider	1.0	1.0	1.0
Nurse II	1.0	1.0	1.0
Nurse I (staff nurse)	2.0	0.0	0.0
Correctional Clinical Security Officer II	1.0	1.0	1.0
Client Care Aide II	2.0	2.0	2.0
Shift I Sub Total	**7.0**	**5.0**	**5.0**
Direct Care Nursing Shift II			
Nurse III (Shift Supervisor)	3.5	3.5	0.0
Health Care Tech I (LPT/LPN)	2.0	2.0	1.0
Health Care Tech II (LPT/LPN)	1.0	1.0	0.0
Client Care Aide II	1.0	1.0	1.0
Shift II Sub Total	**7.5**	**7.5**	**2.0**
Direct Care Nursing Shift III			
Nurse III (Shift Supervisor)	1.8	1.4	1.4
Nurse I (Staff Nurse)	1.0	1.0	1.0
Client Care Aide II	2.0	2.0	0.0
Shift III Sub Total	**4.8**	**4.4**	**2.4**

TABLE 3: Staffing Scenarios	Optimal Staffing	Intermediate Staffing	Minimum Necessary (Request)
Nursing - All Shifts Total	**19.3**	**16.9**	**9.4**
Non-Nursing Professionals			
Non-Nursing Professional *Direct* Care			
Music Therapist	1.0	1.0	1.0
Recreation Therapist	1.0	1.0	1.0
Teachers	1.0	1.0	1.0
Speech Therapist	0.5	0.0	0.0
Physical Therapist	1.0	1.0	1.0
Non-Nursing Professional *Indirect* Care			
Psychiatrists	NA	NA	NA
Internal Medicine	NA	NA	NA
Physician Asst./Nurse Practitioner	NA	NA	NA
Clinical Team Leader	1.0	1.0	1.0
Admin Asst (Ward Clerk)	2.0	1.0	1.0
Material Handlers	1.0	0.0	0.0
Correctional Clinical Security Officer I	2.6	2.6	2.6
Correctional Clinical Security Officer II	1.6	1.6	1.6
Correctional Clinical Security Officer III	1.6	1.6	1.6
Division Chief Nurse	1.0	0.0	0.0
Pharmacy II	1.0	1.0	1.0
Dietician	0.5	0.5	0.5
Non-Nursing Professional Sub Total	**16.8**	**13.3**	**13.3**
Non-Nursing Professional Direct Care Sub Total	**4.50**	**4.0**	**4.0**
Nursing Direct Care Sub Total	**19.3**	**16.9**	**9.4**
Total Direct Care (Nursing & Prof)	**23.8**	**20.9**	**13.4**

TABLE 3: Staffing Scenarios	Optimal Staffing	Intermediate Staffing	Minimum Necessary (Request)
Total FTEs Direct and Indirect	**36.0**	**30.2**	**22.7**

Source: Colorado Mental Health Institute at Pueblo, Institute for Forensic Psychiatry

Definitions for the different staffing levels are included below:

Optimal Staffing - The number of hospital employees required to meet professional standards of care. This number will allow staff to be available to provide clinical and rehabilitation services for effective and efficient patient recovery. (Research suggests that the number of seclusion and restraint hours have a direct link to the direct staff to patient ratio. Sufficient clinical staff are required to provide the behavioral treatment plans and other psychosocial treatment approaches thus reducing the need to manage the patient with the use of external controls (Donate, Neal and Addle ton, 1991). Sufficient quality staff has a direct correlation to patient safety, recovery and reduction of liability to hospitals.

Intermediate Staffing - The number of hospital employees required to meet the basic physical management and care of patients with safety and custodial oversight of the patients as the focus. When staffing is insufficient to provide the rehabilitative services required for severely impaired patients, the use of seclusion and restraint is a common method of managing mentally ill patients. Schwab and Limier carried out an empirical study of seclusion and found the lack of available staff contributed to the use of seclusion.

Minimum Staffing: - The number of hospital employees required to implement security and physical control of the facility. This number of staff maintains control of the buildings through searches, implementation of restrictive security policies and restrictive rules (1995 Blackwell Science Ltd, Journal of Advanced Nursing, 22, 1193-1202). This option provides for minimum number of staff to provide supervision for most patients and limited treatment.

In addition to the shortcomings of previous operating estimates, some of the requirements of Neiberger have resulted in CMHIP having fewer staff to transfer to the new facility. The *Neiberger Settlement Agreement* required that CMHIP establish a Forensic Community Based Services (FCBS) outpatient program, which required that CMHIP transfer eight (8) staff from inpatient care to this new program to satisfy the settlement ratio of case managers to patients in the program. This requirement left CMHIP with eight fewer staff to transfer to the new HSFI.

As a result of these two circumstances (an overly conservative initial staffing methodology and the Neiberger-required transfer of FTEs), the Department is requesting an additional 10.0 FTE and $702,707, to enhance the Department's ability to, at a minimum, operate the facility at full capacity (200 beds) with some appropriate therapeutic activity programming. The specialized units and the Treatment Mall will allow for the provision of various concurrent activities for up to 200 patients, each with individualized treatment plans. This means that staff can run multiple group and individual therapies, vocational and life skills training and recreational activities all at the same time, if sufficient staff are provided to conduct such activities and maintain security and appropriate staffing on the units.

Attachment 2: Detailed Calculations

Attachment 2 includes 15 separate tables itemizing the calculations for both components (updated operating estimate and additional staff) of the FY 2008-09 request and the costs to annualize this request in FY 2009-10. A description of each table follows:

Attachment 2: Table 1

Table 1 is a summary of the request for FY 2008-09 and FY 2009-10 by Long Bill section and line item and itemizes the major components of the request.

Attachment 2: Tables 2 & 3 – Updated Operating Estimate: HSFI on-going staffing for additional 12 beds, FY 2008-09 & FY 2009-10

Table 2 includes the FTE associated with the portion of this request associated with the updated FY 2007-08 capital construction operating estimate. It shows, by job

classification, the 12.7 FTE staff that will be hired in FY 2008-09 and will be a part of the on-going operations of the HSFI in FY 2009-10. It represents the balance of the original 59.4 FTE estimated in the FY 2007-08 HSFI capital construction request (*Attachment 4- CMHIP-Forensics Replacement & Heat Plant Expansion, Phase IV of IV, pg 4-11*), less the 46.7 FTE received in the FY 2006-07 supplemental/budget amendment funding for the 20-bed competency evaluation and restoration unit (see Table 2 above). Table 3 shows the annualization cost of the 12.7 FTE. The requested FTE focus on the additional direct care and staffing support needed for an additional 12 beds.

Attachment 2: Tables 4 & 5 – Additional security and therapeutic FTE for FY 2008-09 and FY 2009-10

The Department has determined that an additional 10 FTE are needed to meet the minimum staffing level necessary to operate the new facility, including the provision of adequate therapeutic programming and sufficient staffing for the needs of the specialized units (e.g. skilled nursing, etc.). This facility will house patients with the highest acuity levels of any inpatient psychiatric hospital in Colorado. As a result, these patients require intensive programming, while maintaining tight security and supervision throughout the facility. Previous estimates of the operating costs of the new facility did not account for the therapeutic programming opportunities and the levels of supervision required to operate multiple programs at once. In addition, the CMHIP will have 8.0 fewer FTE to transfer to the HSFI, because these staff were required to be reallocated the Forensic Community Based Services (FCBS); this request will make up for the reallocation of these staff to this outpatient program.

Attachment 2: Tables 6, 7 & 8: One-Time Temporary Staffing for Dining, Nursing and Security Services

Operation of the new HSFI will require substantial training for staff as well as careful and incremental transition of patients into the new facility. One of the primary features of the new facility is the security infrastructure. Staff will need to learn how they will move through the building, how they will transition patients through the building, and what types of staffing levels and monitoring are required for each distinct space in the

facility. In FY 2008-09, a small number of temporary nutrition and public safety staff are needed to run an additional guard post and dining room in June 2009 while patients are moving between buildings, when the HSFI is open and existing medium- and maximum- security units are not yet closed.

Attachment 2: Tables 9 & 10 – On-Going General Hospital & Outside Medical Costs
Both Mental Health Institutes are experiencing increased medical costs for their patients of 20-30%. Although medical care was not included in the original FY 2007-08 capital construction-operating estimate, CMHIP cannot afford to absorb the medical costs associated with this increase in patient population. Costs for the General Hospital were included in the FY 2006-07 supplemental/budget amendment funding for the 20-bed competency evaluation and restoration unit, however this figure was based on an *estimated* per patient per day cost because the *FY 2005-06 Medicare Cost Report* had not been completed at that time. Based on the final *FY 2005-06 Medicare Cost Report*, the General Hospital cost for a total of 32 beds is lower than what was approved in the FY 2006-07 supplemental/budget amendment funding for the 20-bed competency evaluation and restoration unit, therefore the Department is requesting to *reduce* the appropriation for the General Hospital by $29,501 (*Attachment 2: Table 8*). Table 9 calculates the per patient per day "Outside Medical" cost for an additional 32 beds using the *FY 2005-06 Medicare Cost Report*. This reflects the average cost for medical care for forensics patients that cannot be provided by the General Hospital and requires an outside vendor. Since it is not anticipated that the HSFI will be full in June 2009, no funding is requested for outside medical until FY 2009-10.

Attachment 2: Table 11 – On-Going Patient and Staff Operating
Table 11 reflects updated costs for the patient and staff operating estimates that were included in the FY 2007-08 capital construction operating estimate. The staff operating cost reflects FY 2008-09 common policy to include $500 per person for all requested FTE. For on-going patient operating costs, the Department used the *FY 2005-06 Medicare Cost Report* to isolate the food costs and dining operating costs to arrive at a $7.81 per patient per day cost. This cost was not inflated by 2% because it is

significantly higher than the original $4.45 cost per patient identified in the FY 2007-08 capital construction operating request. Similar to the medical cost calculation described above, the Department is requesting the difference between the updated patient operating amount for 32 beds, less the patient operating funding received for the FY 2006-07 supplemental/budget amendment funding for the 20-bed competency evaluation and restoration unit. This funding is only requested for FY 2009-10 and the Department will absorb the minimal cost increases in this area in FY 2008-09. In addition, this table includes $10,000 associated with using Department of Corrections inmates to move and set up furniture and equipment in the new facility.

Attachment 2: Table 12 – On-Going Funding for Pharmaceuticals
The per patient per day cost for pharmaceuticals included in the capital construction operating estimate has been updated using the *FY 2005-06 Medicare Cost Report*, which was then inflated by 2% through FY 2009-10. Therefore, the request reflects the difference between the updated cost in the FY 2007-08 capital construction operating estimate and the pharmaceutical funding received in the FY 2006-07 supplemental/budget amendment funding for the 20-bed competency evaluation and restoration unit. Two percent inflation was used as a conservative growth factor, assuming that if pharmaceuticals increased significantly, the Department would need to request additional funding for all pharmaceuticals across the MHIs.

Attachment 2: Table 13 – Library and Minor Furnishings
This table reflects the costs from the FY 2007-08 capital construction operating estimate inflated by 2%. The Department's request differs slightly from the capital construction operating estimate in that a different configuration of supplies is requested. The Department reduced the amount requested for the library/learning center and instead is requesting a portion of this funding be applied to purchase critical physical therapy equipment such as wheelchairs and other walking aides. These types of equipment and minor furnishings (e.g. lamps, etc.) are not included in the capital construction request associated with the new building. Instead they are considered capital outlay and therefore must be requested as a part of the Department's operating request.

Attachment 2: Table 14 – Capital Outlay for the Medical Unit
This portion of the request was not included in the FY 2007-08 capital construction operating estimate for the new HSFI, but it provides capital outlay dollars for a critical new feature in the HSFI. Capital outlay is not included in the furnishings and fixtures portion of the capital construction request and therefore must be requested with this operating request. One of the primary objectives of the new facility was to reduce the need to transport patients outside the secure setting. To accomplish this, the HSFI will have a medical unit designed to manage a number of medical procedures within its walls. Transporting patients to and from medical appointments, even on CMHIP campus grounds, is a very staff intensive process. For example, two to three staff from the ward must accompany the patient to the General Hospital or to the laboratory, leaving the ward temporarily short staffed. This unit will minimize staff leaving the facility and reduce the risks associated with patients leaving a secure setting. Therefore, the Department is requesting $15,159 in capital outlay expenditures for this new unit.

Attachment 2: Table 15 – Constant Factors Used in Calculations
This table includes common policy calculators and shift differential calculations that were used in the staffing requests.

Impact on Other Government Agencies:

There is no financial impact on other governmental agencies associated with this request. The request will have a positive impact on the Department of Corrections ability to manage mentally ill patients and will continue CMHIP's success at maintaining a waiting list for competency evaluations and restorations that is acceptable to the courts.

Cost Benefit Analysis:

When the new HSFI opens it is expected that all beds will be filled and that the clinical requirements of the Neiberger lawsuit (as described above) will be addressed. A conservative figure for the cost of Neiberger to the State was $1,720,436, however this figure did not include additional costs paid out of the Risk Management fund and CMHIP staff time, travel and other costs related to an increase in operational demands under lawsuit conditions. If these legal costs were inflated by 10% to account for CDHS ancillary costs, the cost of the lawsuit would rise to $1,892,480, which is $147,147 greater than the annualized cost of this request in FY 2009-10. This is a high

profile building for the judges, lawyers and court monitors that were involved in the *Neiberger* lawsuit. Therefore, a legal assessment and judgment of the State's the implementation and operation of this facility is likely.

In addition, the new facility is expected to greatly improve the therapeutic programming for medium- and maximum-security patients. With patients receiving active treatment according to individualized treatment plans, the opportunities for progressing more patients to community settings increases. It currently costs $479 per patient per day in the IFP. Every 10 people retained in forensics one year longer than necessary equates to $1.8 million, which is greater than the annualized FY 2009-10 request; 10 people is only 5% of the population at the new HSFI. The HSFI provides the opportunity for the State to operate its forensics program more efficiently by better meeting the demand for forensics services, providing more services to more people and moving them into the community as quickly as possible. This outcome will result in a greater number of people served at a lower cost per person to the State and more efficient use of one of the State's significant assets.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	April 2007 – June 2009 (Most recent Period of planning activity)
Purchase Furniture and Equipment	November 2008
FTE Hired	Starting January 2009 - June 2009
Building Systems Testing	January & February 2009
Train Staff	March, April & May 2009
Start-Up Date	Begin to transition patients June 2009

Source: Colorado Mental Health Institute at Pueblo, Institute for Forensic Psychiatry.

Statutory and Federal Authority:

Sections 16-8-101 thru 122, C.R.S. (2006) (Insanity – Incompetence – Release)

16-8-101 Insanity defined - offenses committed before July 1, 1995.

(1) The applicable test of insanity shall be, and the jury shall be so instructed: "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 that act is not accountable. 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.".

(2) The term "diseased or defective in mind", as used in subsection (1) of this section, does not refer to an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

(3) This section shall apply to offenses committed before July 1, 1995.

16-8-101.3. Legislative intent in enacting section 16-8-101.5 and in making conforming amendments.

The intent of the general assembly in enacting section 16-8-101.5 and making conforming amendments to sections 16-8-101 to 16-8-104, 16-8-106, 16-8-110, 16-8-114, 16-8-115, and 16-8-120 in 1995, and in enacting clarifying provisions in this section and sections 16-8-104.5 and 16-8-105.5 and making conforming amendments to sections 16-8-105 and 16-8-107 and sections 18-1-802 and 18-1-803, C.R.S., in 1996, was to combine the defense of not guilty by reason of insanity and the affirmative defense of impaired mental condition into the affirmative defense of not guilty by reason of insanity and to create a unitary process for hearing the issues raised by said affirmative defense to apply to offenses committed on or after July 1, 1995.

16-8-101.5. Insanity defined - offenses committed on and after July 1, 1995.

(1) The applicable test of insanity shall be:

(a) 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 that act is not accountable; except that 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; or

(b) A person who suffered from a condition of mind caused by mental disease or defect that prevented the person from forming a culpable mental state that is an essential element of a crime charged, 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 because, when the act is induced by any of these causes, the person is accountable to the law.

(2) As used in subsection (1) of this section:

(a) "Diseased or defective in mind" does not refer to an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

(b) "Mental disease or defect" includes only those severely abnormal mental conditions that grossly and demonstrably impair a person's perception or understanding of reality and that are not attributable to the voluntary ingestion of alcohol or any other psychoactive substance but does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

(3) This section shall apply to offenses committed on or after July 1, 1995.

16-8-102. Other definitions.

As used in this article, unless the context otherwise requires:

(1) "Competency examination" means a court-ordered examination of a defendant either before, during, or after trial, directed to developing information relevant to a determination of his competency to proceed at a particular stage of the criminal proceeding.

(2) "Competency hearing" means a hearing to determine whether a defendant is competent to proceed.

(2.7) (a) "Impaired mental condition" means a condition of mind, caused by mental disease or defect that prevents the person from forming the culpable mental state that is an essential element of any crime charged. For the purposes of this subsection (2.7), "mental disease or defect" includes only those severely abnormal mental conditions which grossly and demonstrably impair a person's perception or understanding of reality and which are not attributable to the voluntary ingestion of alcohol or any other psychoactive substance; except that it does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

(b) This subsection (2.7) shall apply only to offenses committed before July 1, 1995.

(3) "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.

(4) "Ineligible for release" means the defendant is suffering from a mental disease or defect which is likely to cause him to be dangerous to himself, to others, or to the community, in the reasonably foreseeable future, if he is permitted to remain at liberty.

(4.5) "Ineligible to remain on conditional release" means the defendant has violated one or more conditions in his release, or the defendant is suffering from a mental disease or defect which is likely to cause him to be dangerous to himself, to others, or to the community in the reasonably foreseeable future, if he is permitted to remain on conditional release.

(4.7) "Mental disease or defect" means only those severely abnormal mental conditions that grossly and demonstrably impair a person's perception or understanding of reality and that are not attributable to the voluntary ingestion of alcohol or any other psychoactive substance; except that it does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

(5) "Release examination" means a court-ordered examination of a defendant directed to developing evidence relevant to determining whether he is eligible for release.

(6) "Release hearing" means a hearing for the purpose of determining whether a defendant previously committed to the department of human services, following a verdict of not guilty by reason of insanity, has become eligible for release.

(7) "Restoration hearing" means a hearing to determine whether a defendant who has previously been determined to be incompetent to proceed has become competent to proceed.

(8) "Sanity examination" means a court-ordered examination of a defendant who has entered a plea of not guilty by reason of insanity, directed to developing information relevant to determining the sanity or insanity of the defendant at the time of the commission of the act with which he is charged and also his competency to proceed.

16-8-103. Pleading insanity as a defense.

(1) (a) The defense of insanity may only be raised by a specific plea entered at the time of arraignment; except that the court, for good cause shown, may permit the plea to be entered at any time prior to trial. The form of the plea shall be: "Not guilty by reason of insanity"; and it must be pleaded orally either by the defendant or by the defendant's counsel. A defendant who does not raise the defense as provided in this section 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 the defendant's mental condition as bearing upon his or her capacity to form the required specific intent. The plea of not guilty by reason of insanity includes the plea of not guilty.

(b) This subsection (1) shall apply only to offenses committed before July 1, 1995.

(1.5) (a) The defense of insanity may only be raised by a specific plea entered at the time of arraignment; except that the court, for good cause shown, may permit the plea to be entered at any time prior to trial. The form of the plea shall be: "Not guilty by reason of insanity"; and it must be pleaded orally either by the defendant or by the defendant's counsel. The plea of not guilty by reason of insanity includes the plea of not guilty.

(b) This subsection (1.5) shall apply to offenses committed on or after July 1, 1995.

(2) If counsel for the defendant believes that a plea of not guilty by reason of insanity should be entered on behalf of the defendant but the defendant refuses to permit the entry of the plea, counsel may so inform the court. The court shall then conduct such investigation as it deems proper, which may include the appointment of psychiatrists or psychologists to assist a psychiatrist to examine the defendant and advise the court. After its investigation the court shall conduct a hearing to determine whether the plea should be entered. If the court finds that the entry of a plea of not guilty by reason of insanity is necessary for a just determination of the charge against the defendant, it shall enter the plea on behalf of the defendant, and the plea so entered shall have the same effect as though it had been voluntarily entered by the defendant himself.

(3) If there has been no grand jury indictment or preliminary hearing prior to the entry of the plea of not guilty by reason of insanity, the court shall hold a preliminary hearing prior to the trial of the insanity issue. If probable cause is not established, the case shall be dismissed, but the court may order the district attorney to institute civil proceedings pursuant to article 10 of title 27, C.R.S., if it appears that the protection of the public or the accused requires it.

(4) Before accepting a plea of not guilty by reason of insanity, the court shall advise the defendant of the effect and consequences of the plea.

16-8-103.5. Impaired mental condition - when raised - procedure - legislative intent.

(1) If the defendant intends to assert the affirmative defense of impaired mental condition, he shall indicate that intention to the court and to the prosecution at the time of arraignment; except that the court, for good cause shown, shall permit the defendant to inform the court and the prosecution of his intention to assert the affirmative defense of impaired mental condition at any time prior to trial.

(2) If counsel for the defendant believes that an assertion of the affirmative defense of impaired mental condition should be entered on behalf of the defendant but the defendant refuses to permit counsel to offer such evidence, counsel may so inform the court. The court shall then conduct such investigation as it deems proper, which may include the appointment of psychiatrists or psychologists to assist a psychiatrist to examine the defendant and advise the court. After its investigation, the court shall conduct a hearing to determine whether evidence of impaired mental condition should be offered at trial. If the court finds that such a defense is necessary for a just determination of the charge against the defendant, it shall inform the prosecution that such defense shall be asserted at trial by the defendant and shall order the defendant's counsel to present evidence at trial on the defense of impaired mental condition.

(3) At the time at which the defendant announces his intention to assert the affirmative defense of impaired mental condition, the court shall advise the defendant of the effect and consequences of asserting the defense.

(4) When the defendant indicates his intention to assert the defense of impaired mental condition, the court shall order an examination of the defendant pursuant to section 16-8-106. The court shall order both the prosecutor and the defendant to exchange the names, addresses, reports, and statements of persons, other than medical experts subject to the provisions of section 16-8-103.6, whom the parties intend to call as witnesses with regard to the affirmative defense of impaired mental condition.

(5) If the truer of fact finds the defendant not guilty by reason of impaired mental condition, pursuant to section 18-1-803 (3), C.R.S., the court shall commit the

defendant to the custody of the department of human services until such time as he is found eligible for release, pursuant to the standards set forth in sections 16-8-115 and 16-8-120. The executive director of the department of human services shall designate the state facility at which the defendant shall be held for care and psychiatric treatment and may transfer the defendant from one institution to another if in the opinion of the director it is desirable to do so in the interest of the proper care, custody, and treatment of the defendant or the protection of the public or the personnel of the facilities in question.

(6) It is the intent of the general assembly that the assertion of the affirmative defense of impaired mental condition not be made in such a fashion that it is used to circumvent the requirements of disclosure specified in rule 16 of the Colorado rules of criminal procedure.

(7) A defendant may raise impaired mental condition only through an assertion of affirmative defense.

(8) This section shall apply only to offenses committed before July 1, 1995.

16-8-103.6. Waiver of privilege.

(1) (a) A defendant who places his or her mental condition at issue by pleading not guilty by reason of insanity pursuant to section 16-8-103, asserting the affirmative defense of impaired mental condition pursuant to section 16-8-103.5, raising the question of incompetency to proceed pursuant to section 16-8-110, or disclosing witnesses who may provide evidence concerning the defendant's mental condition during a sentencing hearing held pursuant to section 18-1.3-1201 or 18-1.3-1302, C.R.S., waives any claim of confidentiality or privilege as to communications made by the defendant to a physician or psychologist in the course of an examination or treatment for such mental condition for the purpose of any trial, hearing on the issue of such mental condition, or sentencing hearing conducted pursuant to section 18-1.3-1201 or 18-1.3-1302, C.R.S. The court shall order both the prosecutor and the defendant to

exchange the names, addresses, reports, and statements of any physician or psychologist who has examined or treated the defendant for such mental condition.

(b) This subsection (1) shall apply only to offenses committed before July 1, 1995.

(2) (a) A defendant who places his or her mental condition at issue by pleading not guilty by reason of insanity pursuant to section 16-8-103, raising the question of incompetency to proceed pursuant to section 16-8-110, or disclosing witnesses who may provide evidence concerning the defendant's mental condition during a sentencing hearing held pursuant to section 18-1.3-1201 or 18-1.4-102, C.R.S., or, for offenses committed on or after July 1, 1999, by seeking to introduce evidence concerning his or her mental condition pursuant to section 16-8-107 (3) waives any claim of confidentiality or privilege as to communications made by the defendant to a physician or psychologist in the course of an examination or treatment for such mental condition for the purpose of any trial, hearing on the issue of such mental condition, or sentencing hearing conducted pursuant to section 18-1.3-1201 or 18-1.4-102, C.R.S. The court shall order both the prosecutor and the defendant to exchange the names, addresses, reports, and statements of any physician or psychologist who has examined or treated the defendant for such mental condition.

(b) This subsection (2) shall apply to offenses committed on or after July 1, 1995.

16-8-103.7. Examination after entry of defenses of insanity and impaired mental condition.

(1) (a) When, at the time of arraignment, the defense of insanity is raised, pursuant to section 16-8-103, and the defendant asserts his or her intention to raise the affirmative defense of impaired mental condition, pursuant to section 16-8-103.5, the court shall order one examination of the defendant with regard to both defenses pursuant to section 16-8-106.

(b) This subsection (1) shall apply only to offenses committed before July 1, 1995.

(2) (a) When, at the time of arraignment, the defense of insanity is raised pursuant to section 16-8-103, the court shall order an examination of the defendant with regard to the insanity defense pursuant to section 16-8-106.

(b) This subsection (2) shall apply to offenses committed on or after July 1, 1995.

(3) (a) When the defendant gives notice pursuant to section 16-8-107 (3) that he or she intends to introduce evidence in the nature of expert opinion concerning his or her mental condition, the court shall order an examination of the defendant pursuant to section 16-8-106.

(b) The provisions of this subsection (3) shall apply to offenses committed on or after July 1, 1999.

16-8-104. Separate trial of issues.

The issues raised by the plea of not guilty by reason of insanity shall be tried separately to different juries, and the sanity of the defendant shall be tried first. This section shall apply only to offenses committed before July 1, 1995.

16-8-104.5. Single trial of issues.

(1) The issues raised by the plea of not guilty by reason of insanity shall be treated as an affirmative defense and shall be tried at the same proceeding and before the same trier of fact as the charges to which not guilty by reason of insanity is offered as a defense.

(2) This section shall apply to offenses committed on or after July 1, 1995.

16-8-105. Procedure after plea for offenses committed before July 1, 1995.

(1) When a plea of not guilty by reason of insanity is accepted, the court shall forthwith commit the defendant for a sanity examination, specifying the place and period of commitment.

(2) Upon receiving the report of the sanity examination, the court shall immediately set the case for trial to a jury on the issue raised by the plea of not guilty by reason of insanity. In all cases except class 1, class 2, and class 3 felonies, the defendant may waive jury trial by an express written instrument or announcement in open court appearing of record. If the court and the district attorney consent, jury trial may be waived in a class 1, class 2, or class 3 felony case. Every person is presumed to be sane; but, once any evidence of insanity is introduced, the people have the burden of proving sanity beyond a reasonable doubt.

(3) If the trier of fact finds the defendant was sane at the time of commission of the offense, the court, unless it has reason to believe that the defendant is incompetent to proceed or the question is otherwise raised as provided in section 16-8-110, shall immediately set the case for trial on the issues raised by the plea of not guilty. If the question of whether the defendant is incompetent to proceed is raised, the court shall follow the procedure set forth in section 16-8-111.

(4) If the trier of fact finds the defendant not guilty by reason of insanity, the court shall commit the defendant to the custody of the department of human services until such time as he is found eligible for release. The executive director of the department of human services shall designate the state facility at which the defendant shall be held for care and psychiatric treatment and may transfer the defendant from one institution to another if in the opinion of the director it is desirable to do so in the interest of the proper care, custody, and treatment of the defendant or the protection of the public or the personnel of the facilities in question.

(5) This section shall apply to offenses committed before July 1, 1995.

16-8-105.5. Procedure after plea for offenses committed on or after July 1, 1995.

(1) When a plea of not guilty by reason of insanity is accepted, the court shall forthwith commit the defendant for a sanity examination, specifying the place and period of commitment.

(2) Upon receiving the report of the sanity examination, the court shall immediately set the case for trial. Every person is presumed to be sane; but, once any evidence of insanity is introduced, the people have the burden of proving sanity beyond a reasonable doubt.

(3) When the affirmative defense of not guilty by reason of insanity has been raised, the jury shall be given special verdict forms containing interrogatories. The trier of fact shall decide first the question of guilt as to felony charges that are before the court. If the trier of fact concludes that guilt has been proven beyond a reasonable doubt as to one or more of the felony charges submitted for consideration, the special interrogatories shall not be answered. Upon completion of its deliberations on the felony charges as previously set forth in this subsection (3), the trier of fact shall consider any other charges before the court in a similar manner; except that it shall not answer the special interrogatories regarding such charges if it has previously found guilt beyond a reasonable doubt with respect to one or more felony charges. The interrogatories shall provide for specific findings of the jury with respect to the affirmative defense of not guilty by reason of insanity. When the court sits as the trier of fact, it shall enter appropriate specific findings with respect to the affirmative defense of not guilty by reason of insanity.

(4) If the trier of fact finds the defendant not guilty by reason of insanity, the court shall commit the defendant to the custody of the department of human services until such time as the defendant is found eligible for release. The executive director of the department of human services shall designate the state facility at which the

defendant shall be held for care and psychiatric treatment and may transfer the defendant from one facility to another if in the opinion of the director it is desirable to do so in the interest of the proper care, custody, and treatment of the defendant or the protection of the public or the personnel of the facilities in question.

(5) This section shall apply to offenses committed on or after July 1, 1995.

16-8-106. Examinations and report.

(1) All examinations ordered by the court in criminal cases shall be accomplished by the entry of an order of the court specifying the place where such examination is to be conducted and the period of time allocated for such examination. The defendant may be committed for such examination to the Colorado psychiatric hospital in Denver, the Colorado mental health institute at Pueblo, the place where he or she is in custody, or such other public institution designated by the court. In determining the place where such examination is to be conducted, the court shall give priority to the place where the defendant is in custody, unless the nature and circumstances of the examination require designation of a different facility. The defendant shall be observed and examined by one or more psychiatrists during such period as the court directs; except that, if the examination is for the purpose of determining the defendant's competency to proceed, then the competency evaluation shall be conducted by a licensed psychiatrist or a licensed psychologist who is trained in forensic competency assessments, or a psychiatrist or psychologist who is in forensic training and practicing under the supervision of a licensed psychiatrist with expertise in forensic psychiatry or a licensed psychologist with expertise in forensic psychology. For good cause shown, upon motion of the prosecution or defendant, or upon the court's own motion, the court may order such further or other examination, including services of psychologists, as is advisable under the circumstances. Nothing in this section shall abridge the right of the defendant to procure a psychiatric examination as provided in section 16-8-108.