Hearing Before the United States Commission on Civil Rights

AGE DISCRIMINATION IN FEDERALLY-ASSISTED PROGRAMS

HEARING HELD IN

DENVER, COLORADO

JULY 28-29, 1977

VOLUME II: EXHIBITS

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U. S. COMMISSION ON CIVIL RIGHTS

The United States Commission on Civil Rights is a temporary independent, bipartisan agency established by the Congress in 1957 to:

- Investigate complaints alleging denial of the right to vote by reason of race, color, religion, sex, or national origin, or by reason of fraudulent practices;
- Study and collect information concerning legal developments constituting a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, or national origin, or in the administration of justice;
- Appraise Federal laws and policies with respect to the denial of equal protection of the laws because of race, color, religion, sex, or national origin, or in the administration of justice;
- Serve as a national clearinghouse for information concerning denials of equal protection of the laws because of race, color, religion, sex, or national origin; and
- Submit reports, findings, and recommendations to the President and Congress.

MEMBERS OF THE COMMISSION

Arthur S. Flemming, *Chairman*
Stephen Horn, *Vice Chairman*
Frankie M. Freeman
Manuel Ruiz, Jr.
Murray Saltzman
John A. Buggs, *Staff Director*

By the Older Americans Amendments of 1975, the U.S. Commission on Civil Rights was directed to: investigate unreasonable age discrimination in federally-assisted programs; report the findings of the investigation to Congress, the President, and affected Federal agencies; recommend statutory changes or administrative actions based on its findings; and draft general regulations for implementation of the Age Discrimination Act of 1975.

CONTENTS

EXHIBITS

Exhibit No. 1

COMMISSION ON CIVIL RIGHTS

HEARING ON AGE DISCRIMINATION

Denver, Colorado

Notice is hereby given pursuant to the provisions of the Civil Rights Act of 1957, as amended, 42 U.S.C. 1975 et seq. (1976), that the U.S. Commission on Civil Rights will hold a public hearing in Denver, Colorado dealing specifically with the provisions of the Age Discrimination Act of 1975, enacted as part of the Older Americans Amendments of 1975, 42 U.S.C. 6101 et seq. (1976). The hearing will be held on July 28 and 29, 1977 at the Federal Building Courthouse, Room 2330, 1961 Stout Street, Denver, Colorado. The hearing will begin each day at 8:30 a.m. An Executive Session, if appropriate, will be convened on June 28 at the same location as the hearing.

The purpose of the hearing is to elicit the views of interested parties, including Federal departments and agencies, on issues relating to age discrimination in programs and activities receiving Federal financial assistance and, particularly with respect to the reasonableness of distinguishing on the basis of age among potential participants in, or beneficiaries of, specific federally assisted programs.

The hearing will give particular attention to the following federally assisted programs and activities: Comprehensive Employment and Training Act Public Service Employment Programs; Community Mental Health Centers; Community Health Centers; Vocational Rehabilitation; Legal Services; Title XX of the Social Security Act; Food Stamps; Medicaid; and selected areas in the field of Education.

Dated at Washington, D.C., June 15, 1977.

ARTHUR S. FLEMMING,
Chairman.

[FR Doc.77-18029 Filed 6-23-77;8:45 am]

Exhibit No. 2

MAJOR PUBLIC MENTAL HEALTH TREATMENT FACILITIES IN COLORADO

COMPREHENSIVE MENTAL HEALTH CENTERS

1. ADAMS COUNTY MENTAL HEALTH CENTER
   4131 East 72nd Avenue
   Commerce City 80022
   287-9201

2. ARAPAHOE MENTAL HEALTH CENTER
   4857 South Broadway
   Englewood 80110
   761-9220

3. BETHESDA HOSPITAL AND
   MENTAL HEALTH CENTER
   4400 E. Iliff Avenue
   Denver 80222
   757-1211

4. MENTAL HEALTH CENTER OF BOULDER
   1333 Iris Avenue
   Boulder 80302
   443-8500

5. COLORADO WEST REGIONAL MENTAL HEALTH CENTER
   P.O. Box 1589
   Glenwood Springs 81601
   945-5933

6. JEFFERSON COUNTY MENTAL HEALTH CENTER
   9908 W. Cedar Avenue
   Lakewood 80226
   239-9536

7. MALCOLM X CENTER FOR MENTAL HEALTH
   2222 East 18th Avenue
   Denver 80205
   320-5849

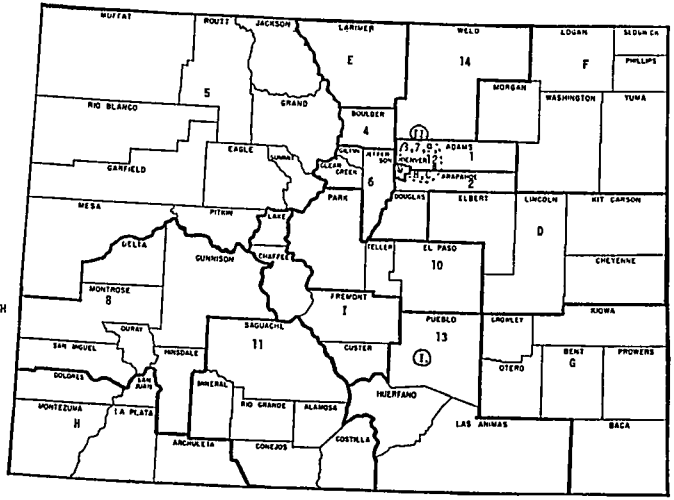
8. NORTHWEST COLORADO MENTAL HEALTH CENTER
   P.O. Box 1208
   Montrose 81401
   249-3694

9. NORTHWEST DENVER MENTAL HEALTH CENTER
   West 8th and Cherokee Streets
   Denver 80204
   893-7533

10. PIKES PEAK FAMILY COUNSELING AND MENTAL HEALTH CENTER
    1353 South 8th Street
    Colorado Springs 80906
    471-8300

11. SAN LUIS VALLEY COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER
    1015 Fourth Street
    Alamosa 81101
    589-3671

12. SOUTHWEST DENVER COMMUNITY MENTAL HEALTH SERVICES
    3702 West Mississippi Avenue
    Denver 80219
    922-3673



MENTAL HEALTH CLINICS

A. AURORA MENTAL HEALTH CENTER
   1575 Elmira
   Aurora 80011
   344-5075

B. CHILDREN'S AND ADOLESCENTS' MENTAL HEALTH SERVICES
   The Children's Hospital
   1056 East 19th Avenue
   Denver 80218
   861-8888 Ext 2372

C. DENVER MENTAL HEALTH CENTER
   1760 High Street
   Denver 80218
   388-3627

D. EAST CENTRAL COLORADO MENTAL HEALTH CLINIC
   3rd. Street and Pawnee Avenue
   Flagler 80815
   765-4825

E. LARIMER COUNTY MENTAL HEALTH CLINIC
   1020 Doctors Lane
   Fort Collins 80521
   482-1407

F. NORTHEAST COLORADO MENTAL HEALTH CLINIC
   916 South 7th Avenue
   Sterling 80751
   522-4392

G. SOUTHEASTERN COLORADO FAMILY GUIDANCE CENTER
   P.O. Box 678
   La Junta 81050
   384-5446

H. SOUTHWEST COLORADO MENTAL HEALTH CENTER
   1919 Main Avenue
   Durango 81301
   247-5245

I. WEST CENTRAL MENTAL HEALTH CLINIC
   323 North 6th.
   Canon City 81212
   275-6400

13. SPANISH PEAKS MENTAL HEALTH CENTER
    401 Michigan
    Pueblo 81004
    544-6373

14. WELD MENTAL HEALTH CENTER
    1220 11th Avenue
    Greeley 80631
    353-3686

COLORADO STATE HOSPITAL SYSTEM

(I) COLORADO STATE HOSPITAL
    1600 West 24th Street
    Pueblo 81003
    543-1170

(II) FORT LOGAN MENTAL HEALTH CENTER
     3520 West Oxford Avenue
     Denver 80236
     761-0220

Exhibit No. 3

EVALUATION REPORT 19

CLIENT CHARACTERISTICS

For All Admission Episodes
First Half of FY 1976-77

July 14, 1977

Robert B. Abelson, Ph.D.
Director,
Statistical Analysis & Research

J. Paul Myers, Jr., M.S.
Senior Research Assistant

Nancy C. Wilson, R.N., M.A.
Researcher III

STATE OF COLORADO

DEPARTMENT OF INSTITUTIONS

DIVISION OF MENTAL HEALTH

CLIENT CHARACTERISTICS
For All Admission Episodes
First Half of FY 1976-77
(July 1, 1976-December 31, 1976)

This report presents Client Admission Form (PES-7) data for all clients admitted to the community agencies and state hospitals within the Colorado public mental health system. These data are for all admissions from July 1, 1976 through December 31, 1976 (the first half of FY 1976-77).

The tables in this report are identical in format to those in Orchid 18, "Client Characteristics for all Admission Episodes, FY 1975-76." Each table presents a Client Admission Form variable and shows for each agency the total number of processed admission forms for the first six months of FY 1976-77. This is followed by the number of unuseable forms for the variable (i.e., blanks or out-of-range). Then the revised total of useable processed admission forms appears. It is from this latter total that the actual numbers and percentages for the categories of that variable are derived, constituting the bulk of a given table. Group totals appear at the bottom of each table.

All of the Client Admission Form variables (except the agency-defined special variables) are included in this report. They appear here in the same order as on the form.

Because of the unuseable processed forms, the distribution of numbers of admissions for a given variable is not quite accurate. In obtaining such numbers we generally assume accuracy for the percentages and apply these percentages to Attendance Summary Form (PES-6A) data. The annual admission figures will be published in a forthcoming Attendance Summary Form Orchid. Also, this present report will be updated for the entire fiscal year as soon as all the forms are processed.

Our usual word of caution: if, in your analyses, an agency is quite atypical for a given variable, check with that agency or the Division before accepting the questionable data. Also, if any of your data are incorrect, please let us know.

CONTENTS

Frequency Tabulation of Admission Episodes attached to this exhibit is on file at the U.S. Commission on Civil Rights.

Exhibit No. 3a

THE DAVIS INSTITUTE

A Multidisciplinary Research and Care Center in the Field of Aging

THE DAVIS INSTITUTE

A Focal Point for Training in Gerontology

THE DAVIS INSTITUTE

A Partnership between the Public and Private Sector

Dedicated to Improving the Quality of Life in the Later Years for People Everywhere

THE DAVIS INSTITUTE 

Birth of An Idea

Scientific advances have extended the average life span of Americans to the Biblical three score years and ten, but for some older people this prolongation of life has proved to be a questionable blessing.

Debilitating illnesses....changing customs and attitudes within our society....widely varying abilities among older people to cope with the physical, social, economic, and psychological facets of aging....ever increasing numbers of people who survive into their 80's and 90's....All these factors have combined to make the nearly 25 million older Americans a population especially at risk for illness, infirmity, desolation, and involuntary dependence.

Progress in diagnosing diseases has far surpassed development of therapeutic techniques for identifying, correcting, or overcoming the impact of illness on the individual. Even more fundamental is our need for a better understanding of the aging process itself, a phase of continued development within the human life cycle.

The study of aging constitutes the next major frontier in health and social sciences research. It is an intellectually and emotionally exciting field of study which is of universal relevance. The Davis Institute for the Care and Study of the Aging was established in Denver to further our knowledge of aging and to improve our capacity for the care of aging individuals among us. It is dedicated to the enrichment as well as the extension of human life.

THE DAVIS INSTITUTE 

Organization

The Davis Institute is a free-standing, non-profit research and care organization governed by a Board of Trustees which includes the founder of the Institute. Dr. A. J. Kauvar is president of the Institute, and Dr. Eric Pfeiffer is the Institute's acting director. Dr. Kauvar is also manager of the Department of Health and Hospitals of the City and County of Denver, with which the Institute is closely affiliated. Prior to that position, he was a recognized leader in the field of gastroenterology. Dr. Pfeiffer is a nationally recognized authority in the field of care and research on aging who is spending a sabbatical year away from Duke University to assist in the development of the programs of the Davis Institute. Drs. Kauvar and Pfeiffer receive guidance and consultation from a distinguished national advisory council well qualified to help make the Davis Institute a national model of a multidisciplinary research and care center.

The Davis Institute is closely associated with one of the nation's most progressive health agencies, the Denver Department of Health and Hospitals, which includes a new city hospital, county health department, and a unique, decentralized network of outpatient facilties known as the Neighborhood Health Program. Besides benefiting from the support and professional consultation services available through the Department of Health and Hospitals, the Institute also interacts with the diverse resources of the University of Colorado School of Medicine, other colleges and universities in the area, the several human service agencies and departments of the State of Colorado, and many additional educational and professional organizations. A vigorous local advisory board, encompassing practitioners, educators and researchers, provides a broad intellectual support base for the work of the Davis Institute.

THE DAVIS INSTITUTE 

Goals

Goals of the Institute reflect an interest in aging in its broadest sense:

- To initiate and continue fundamental research related to the process of aging.
- To develop new diagnostic and treatment techniques which will be a source of knowledge to all interested in human development and aging.
- To innovate social and behavioral approaches directed at solving gerontological problems involving elderly individuals, their families, and their relationships in the community.
- To serve as a training ground both for those interested in research and for those willing to apply new knowledge to the care of the elderly.

THE DAVIS INSTITUTE 

Programs

Specific programs, which will consist of clinical services, research, and education and training, are designed to make the Davis Institute the focus of knowledge about the field of aging in the Rocky Mountain region.

CLINICAL SERVICES

Cornerstone of the clinical services program will be an outpatient geriatric evaluation center aimed at early recognition of problems and restoration of full and independent function for patients. The evaluation team, when necessary, will make home calls to assess patients' problems and needs.

Other clinical components will include:

- A day care program where elderly people will be assisted in regaining their mental, physical and social skills.
- An inpatient unit where more seriously ill patients will receive intensive evaluation and acute care.
- An independent living center where program participants will be taught to regain their capacity for living in the community.
- A community outreach unit.

RESEARCH

Davis Institute research programs will range from basic investigations of how mammalian cells age, especially human brain cells, to studies of pre-retirement procedures in industry.

Additional projects will cover:

- Studies of special subgroups of the elderly, with a special focus on hispanic, black, inner city, and rural elderly.
- Use of multidimensional functional assessment techniques to determine appropriate treatment plans for long-term care.
- Basic and applied research on how medications affect elderly patients.
- Research on suicide among elderly people.
- Studies of the relationship of older people to other members of their families.

EDUCATION & TRAINING

Because the training received by most health care and social service personnel did not deal with problems of the elderly, emphasis of education and training activities in the Davis Institute will be on catch-up training for these professionals.

Activities also will involve:

- Establishment of a technical assistance program in gerontology.
- Monthly interdisciplinary meetings for area health care providers and research scientists.
- Continuing education programs on aging for physicians and other health care personnel.
- Rotations in the Davis Institute for health care personnel now in training.
- Development of curricula and educational materials on aging for use in the Institute and in other educational programs.
- Programs on the provision of mental health consultations in long-term care facilities.
- Public forums on aging which will provide a resource for elderly people and their families, particularly in the area of life style choices and activities available to older people.

What is the Davis Institute?

The Davis Institute for the Care and Study of the Aging is a research, care and training facility devoted to understanding the aging process and improving the quality of life in the later years. It is named in honor of the Davis family. Marvin Davis, a Denver businessman and philanthropist, provided the initial capital funding for the Institute.

Why a Davis Institute?

The quality of health care available to older citizens in the United States is currently not adequate. New and effective treatment techniques must be developed and made accessible to the growing proportion of elderly in the U.S. population. This need cuts across all disciplines, all socioeconomic sectors, all racial and ethnic groups. Ironically, even though medical science has been responsible for increasing life expectancy by at least 20 years since the turn of the century, society's attitudes and the day-to-day care of elderly patients have not generally kept pace. For example, the present practice of "warehousing" the elderly in nursing homes—rather than helping many of them to become self-sufficient—is a solution which will become less feasible and less acceptable to older persons themselves as the elderly population continues to grow. Specialists in the practice of geriatric medicine are still rare and gerontological training centers are even rarer.

Thus, when Mr. Davis approached Dr. A. J. Kauvar, Manager of Denver's Department of Health and Hospitals, with the idea of making an important contribution in the health field, Dr. Kauvar quickly recognized the opportunity to use the funding offered by Mr. Davis to fill an important gap in the health care delivery field and to place Denver in the leadership role in that area. With the encouragement of the donor, the Davis Institute was founded in March of 1975, and Dr. Kauvar assumed the role of President of the newly formed Institute.

Is it part of the Denver Department of Health and Hospitals?

The Institute is an independent non-profit organization governed by its own Board of Trustees. It has a close working relationship with the Denver Department of Health and Hospitals and also with the University of Colorado School of Medicine.

Why was the physical plant located adjacent to Denver General Hospital?

The Davis Institute was located in immediate proximity to a major municipal health care facility in order to minimize capital expenditures for expensive laboratory and X-ray equipment and to gain certain other economies of shared services. More importantly, it will be mutually beneficial for Denver General Hospital and the Davis Institute to share medical and scientific expertise between the two institutions and thereby improve the quality of care both provide.

Who is eligible for its services?

Any person with problems in adapting to growing older or with the disabilities and diseases associated with old age is eligible for initial evaluation at the Institute. No geographic restrictions are imposed. Persons from all socioeconomic groups will be welcomed. Through the cooperation of the public sector, free services for the poor and indigent will also be provided.

What kind of therapy does it offer?

In addition to a comprehensive initial evaluation of each person, the Institute will offer a variety of levels of treatment and rehabilitation. A geriatric intensive care unit is available for the critically ill older person with multiple types of health problems. The Institute will also operate a self-care rehabilitation unit aimed at restoring physical, mental and social functioning which will allow individuals to remain active and independent members of their community. In addition, ongoing ambulatory medical care will be provided. The Institute is currently making plans for a rehabilitation-oriented daycare program for older adults as well.

How was the Davis Institute financed?

The initial funding for the physical facilities of the Institute—the building, furnishings, and equipment—were provided by a generous gift from Marvin Davis. Ongoing financing of the facility will come from multiple sources. These include federal and state funds for research grants and for training activities as well as for certain experimental clinical service programs. The majority of clinical services will be self-supporting through reimbursement for services through direct patient-pay or third party reimbursement. Donations from private individuals and/or corporations will continue to be important to the overall funding of the Institute. The City and County of Denver will provide start-up funding for the operation of the clinical services facilities.

Will the Davis Institute be a teaching as well as a treatment facility?

Definitely. Various training programs have already begun. These are aimed at providing much-needed workshops and continuing education in the field of aging to health and social services personnel already working with the elderly. The vast majority of such personnel did not receive formal training in the field of aging during their basic professional training. The Institute will also offer educational opportunities for professionals-in-training from the fields of medicine, psychiatry, social work, nursing, occupational and physical therapy. In addition the Institute will disseminate broadly all new research findings and new clinical service techniques.

Will the Davis Institute grant degrees?

There are no current plans to develop degree programs. Instead the Institute will seek to work collaboratively with degree-granting institutions to foster the study of gerontology in their degree-granting curricula.

What can a professional hope to achieve by participating in a Davis Institute training program?

Training programs of the Davis Institute emphasize new professional knowledge and skills but also teaching techniques which are effective and which, in fact, lead to increased knowledge and improved performance on the part of the participating professional. Professional training programs are designed with input from the professionals to be trained to make them maximally relevant to their specific training needs.

Please list the research goals of the Davis Institute.

These goals are many. We must come to understand the basic mental and physical processes of aging. We must come to better understand how medications are handled, absorbed, metabolised, and excreted by older patients. We must come to understand those factors which make for successful adaptation to old age and those social and psychological factors which lead to maladaptation. We must focus on the kind of preparation which is needed for a successful post-retirement life and those factors which can be taught to older persons so that they themselves can assume substantial responsibility for their own physical, mental and social well-being.

How will the Institute's research findings be disseminated?

The Institute already publishes *The Davis Institute Newsletter,* an informative publication in the area of aging, providing new research findings, announcements of training opportunities, and new developments in clinical care. We further plan to issue publications giving new research findings, general principles of working with the elderly, and other informative materials aimed at providing guidelines for coping with aging. These publications will be available to libraries, to individual professionals, and to older persons themselves.

Is the Davis Institute primarily interested in providing services locally, or does it intend to have a wider ranging impact?

The goals of the Institute are to provide new knowledge and new treatment techniques which will benefit all older persons, not only those residing in this region of the country. To be practical, rather than theoretical, such studies cannot be carried out in a vacuum. Only through the provision and documentation of new health care techniques in actual use can such new techniques be developed and evaluated. Thus, it is critical to the success of the study programs for the Institute to be involved in the actual care and delivery of services to elderly persons. While the Institute will only provide short-term direct care to a relatively small number of aging patients, its greatest impact on the quality of life and of health care nationally will be through its role as a model for such care; providing trained professionals; and stimulating other providers regionally and nationally to introduce improved services.

Who are the responsible physicians in charge, and what are their qualifications?

Dr. A. J. Kauvar, President of the Davis Institute, is a board certified specialist in internal medicine and a specialist in gastroenterology. He also serves as the Manager of the Denver City and County Department of Health and Hospitals. He is widely recognized as one of the innovators in the field of health care delivery, championing especially the Neighborhood Health Center concept which has provided effective health care in Denver's low income neighborhoods. He had more than 25 years experience in the private practice of medicine before assuming his role as Manager of Health and Hospitals.

Dr. Eric Pfeiffer, Director of the Davis Institute, is a nationally and internationally known psychiatrist and gerontologist who has done pioneering work in early recognition and treatment of diseases of the elderly, focusing on the need for restoration of functioning and return to independent living in the community. He is also Chairman of the HEW Committee on Mental Health and Illness of the Elderly. The additional

medical staff will include geriatricians, internists, family practitioners, and a number of other medical specialists as well as a select group of consultants in various specialty areas.

Does the Davis Institute have any affiliation with other gerontological centers?

The Institute seeks to work collaboratively with a number of gerontological centers across this country, but especially with other programs in gerontology in the Rocky Mountain Region. Joint research efforts are currently being planned with several such centers.

What is the cost of care at the Institute, and is there any arrangement that can be made to offset some of the expense?

The exact cost of services provided at the Institute will vary with the nature and the duration of the service provided. Medicare, Medicaid, and insurance carriers such as Blue Cross/Blue Shield, Prudential Insurance Company, etc. will reimburse the majority of costs for those who qualify. Some of these insurance programs, however, have a requirement for deductibles or co-insurance, and some services provided at the Institute are not covered by some of these insurance policies. The individual would then be personally responsible for these costs. Cost containment will be an important feature of the programs of the Institute.

Can an individual make application, or is a physician's referral required?

The Institute welcomes referrals for consultation by physicians who seek additional help with the care of their aging patients. On the other hand, direct application may be made by an individual or a family member for evaluation at the Institute.

It is expected that this program will help patients become oriented towards full participation in community life rather than becoming a "well-adjusted hospital patient."

Once admitted, how long should a patient expect to stay?

An out-patient evaluation may take from one to several hours and not necessarily require admission at all. However, if a patient is admitted for in-patient care in the self-care rehabilitation unit, his likely length of stay will be somewhere between one week and several weeks, with an anticipated maximum stay of no more than three months. For longer term treatment, a patient would be referred to an appropriate facility. Persons admitted to the geriatric intensive care unit are expected to remain from several days to several weeks, depending on the severity and complexity of their illnesses.

Does one have to be a Denver resident to gain admission?

No. Residents of any part of the United States are eligible for admission.

If an out-of-town patient does come to Denver for treatment, will the Davis Institute provide housing?

For persons requiring only ambulatory care or evaluation, the Institute will not provide housing. However, out-of-town patients can be put in touch with the most convenient and best lodging facilities that would allow them to come to the Institute for evaluation conveniently and at moderate cost.

If one is selected as an in-patient, what kind of facilities will be provided?

An individual selected as a patient in the self-care rehabilitation unit will not find a typical hospital environment. Instead, the patient will be assigned to an attractive double room with bath furnished more like an apartment than a hospital room. Patients will be asked to make their own beds, to take meals in the very attractive cafeteria (normally meals will not be delivered to the patient's bed), and patients will be encouraged to participate in various social and recreational activities.

What about patients with a critical illness?

The geriatric intensive care unit provides more conventional hospital environment for critically ill patients. However, again, the emphasis will be on restoration of functioning. Even when intensive monitoring of body functions, such as cardiac monitoring, is needed, this is done through methods which allow the greatest degree of personal mobility and freedom. Even these hospital rooms will be attractively decorated, with carpeting throughout. The emphasis throughout the Institute is not only on the hospital experience of the patient, but on the expected return to a full life in his or her community.

Will families be allowed to visit?

By all means, yes. Continuing contact with family members is absolutely critical and is encouraged, not discouraged.

What is the patient capacity of the Davis Institute?

It will accommodate approximately 1,000 ambulatory care patients per year. In addition, there will be 78 self-care rehabilitation beds, 15 geriatric intensive care beds, and some 30 places per day in the Institute's daycare program.

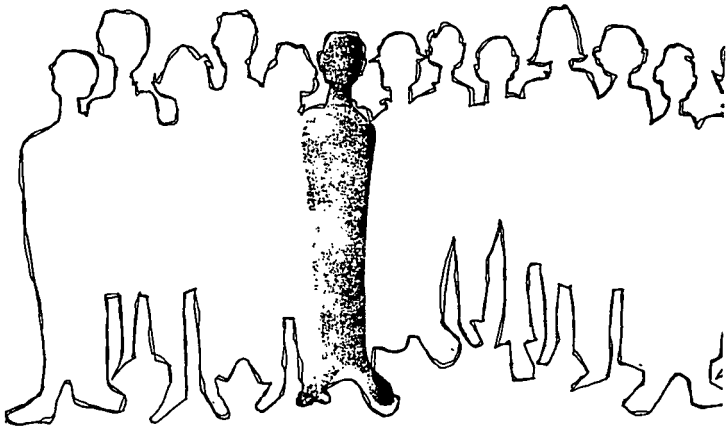
Can the Davis Institute provide such amenities as kosher food, etc. to elderly persons to whom ethnic values are important as a part of treatment?

Yes. In addition, special diets, whether diabetic, high protein, or other specialized diets can be provided.

What can a patient hope to accomplish by coming for therapy?

The Institute's overall goal is to find treatable disease where it exists and to promptly initiate the appropriate treatment or in the case of chronic diseases and disability to prescribe restorative measures which improve functioning of the individual. Optimally, the goal of therapy will be to restore individuals to such a level of function that they can live in the setting of their own choice with minimal dependence on others and with every opportunity to be a fully participating member of their families and communities.

Mental Health Association of Colorado



"YOU CAN MAKE A DIFFERENCE"

THE PROBLEM

Experts say that one person in ten will have some kind of mental health problem - mild to severe - during his or her lifetime.

More than 20 million Americans, more than 250,000 of them in Colorado, currently have some form of mental health problem.

Unfortunately, most of those persons are not being helped because of: inadequate facilities, inadequate information about where to get help, and inadequate information to understand that they need help.

THE SOLUTION

Citizens, *citizens who make a difference,* have been working locally, statewide, and nationally, through their Mental Health Association to improve and develop services and to educate the public about mental health and mental illness.

Over the years, the Mental Health Association of Colorado, its local affiliates, and the national Mental Health Association have been responsible for real progress in mental health.

They include:

Locally - starting crisis "hot lines", having worry clinics, having community seminars about mental health provlems, serving on the boards of local mental health centers and clinics, being volunteers at local centers and clinics, funding Western Interstate Commission of Higher Education (WICHE) scholarships to get promising young persons interested in working in the mental health field.

Statewide - founding Fort Logan Mental Health Center, having an information and referral service for persons needing information about mental health problems, getting a mandatory mental health insurance law passed, providing Christmas gifts for mental patients in the state mental hospitals and in nursing and boarding homes, regularly visiting the state mental health centers, clinics, and hospitals to review services; getting a modern mental health commitment law passed, working on the state mental health plan, and having representatives on the state Mental Health Advisory Council.

Nationally - helping pass the 1963 federal community mental health act that led to more than 600 mental health centers being built in the United States, successfully suing the Nixon Administration to release $126 million in mental health funds, producing a number of major films and pamphlets about mental health, and working with Congress to get research funds for the National Institute of Mental Health.

IT'S UP TO YOU

Currently, there are more than one million Mental Health Association members working to improve the mental health system in the United States.

Each of those persons has a double or triple membership. By joining a local affiliate, you become a member of the state association and the national association.

If you live in an area that doesn't have a local affiliate, joining the state association automatically makes you a member of the national association.

The Mental Health Association of Colorado needs members and money to carry on its efforts.

By joining, you can be counted as another vote for improving the system.

If you want to, and we hope you do, you can volunteer to work on the local or on the state level on any of a number of committees working on public education, legislation, financial development, citizen advocacy, etc.

Memberships are:

Patron Membership $100.00
Donor Membership 50.00
Regular Membership 10.00
Active Membership 5.00
Student/Senior Citizen 2.50
Memorials ..... _____

Please join today.

Remember, the solution is citizens - citizens who make a difference.

MENTAL HEALTH ASSOCIATION OF COLORADO, INC.

1977 GOALS

AGENCY PROGRAM GOALS

A. ON-GOING FACILITATING GOALS

1. Development of the Association's capacity to act as a citizen advocacy agency on behalf of institutionalized clients, persons who may become institutionalized, and those persons who are not receiving proper care by the mental health system.

2. Development of coordination with governmental, voluntary, and educational institutions and organizations working in the field of mental health.

3. Development of capacity to monitor the Colorado Mental Health System.

B. 1977 ISSUE-RELATED GOALS

1. To work through a coordinated public education and social action program to promote the development of a comprehensive system for prevention and treatment of children's mental health problems.

2. To work through a coordinated public education and social action program to promote the development of geographically assessable and comprehensive mental health services in the rural areas of Colorado.

3. To work through a coordinated public education and social action program to monitor and advocate for the promotion and development of a full range of aftercare services to be available to mental health clients throughout Colorado.

CHILDREN'S MENTAL HEALTH

Children represent a high risk population because of the intensity of development of life skills which occurs in the early developmental years. Intervention at an early age can be most effective and prevent long term need to be serviced by the mental health treatment system.

The State Five Year Mental Health Plan talks of treatment in the least restrictive environment. Yet very low goals have been set for increases in children's services, and time-lines are so far in the future that thousands of children will continue to go without the help they need.

Children cannot advocate for themselves. They do not vote and, therefore, have no political clout. They need citizens to advocate for them to fight for the development of children's mental health services in Colorado now.

ISSUES CONCERNING THE ELDERLY

Our society is becoming increasingly, if somewhat belatedly, aware of the special needs of senior citizens. Nevertheless, in most cases community mental health services for the elderly are inadequate. Centers and clinics are not properly staffed to treat the elderly. Mental Health professionals are not trained to deal with the problems of the elderly. Senior citizens are unaware of those services which do exist and fearful of the stigma surrounding mental illness.

Volunteer efforts can be particularly useful with senior citizens--providing transportation to/from medical and mental health facilities, recreation, entertainment; informing senior citizens of available services and programs. The conditions and services offered by nursing and boarding homes around the State is of great concern to many citizens and professionals. The Division of Mental Health's stated goal of moving toward "least restrictive" treatment settings would seem to imply the need to carefully monitor living conditions in nursing and boarding homes and the availability of mental health treatment in these homes who residents tend to be primarily from the elderly population.

July 26, 1977
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ESTIMATES OF THE RESIDENT POPULATION (1) AND NUMBER OF PATIENTS SERVED BY CHC'S (2)

BY AGE - 1976

REGION VIII

		Under 5		5-17 Years		18-44 Years		45-64 Years		65 & Over	
	Total	No.	%	No.	%	No.	%	No.	%	No.	%
Population by Age	6,286,000	525,000	8.4	1,515,000	24.1	2,489,000	39.6	1,173,000	18.7	584,000	9.3
Population Served by CHC's	141,829	19,401	13.7	29,458	20.8	65,430	46.1	18,328	12.9	9,212	6.5
COLORADO											
Population by Age	2,583,000	197,000	7.6	601,000	23.3	1,095,000	42.4	473,000	18.3	218,000	8.4
Population Served by CHC's	131,917	17,913	13.6	26,865	20.4	61,399	46.5	17,334	13.1	8,406	6.4
UTAH											
Population by Age	1,228,000	139,000	11.3	316,000	25.7	481,000	39.2	199,000	16.2	94,000	7.7
Population Served by CHC's	9,525	1,429	15.0	2,477	26.0	3,905	41.0	952	10.0	762	8.0
WYOMING											
Population by Age	390,000	32,000	8.2	93,000	23.8	151,000	38.7	81,000	20.8	34,000	8.7
Population Served by CHC's	387	59	15.2	116	30.0	126	32.6	42	10.9	44	11.4

(1) Current Population Reports Population Estimates and Projections Series P-25 No. 646, Bureau of Census

(2) Bureau of Community Health Service Common Reporting Requirements

Exhibit No. 4

Fiscal Year 1978

Bureau of Community Health Services

Work Plan

CAPACITY BUILDING

The goal of the Capacity Building theme is to strengthen family-oriented primary care components of the health care system through integration of services, and to target resources to risk groups and areas of greatest need. A priority of capacity building efforts is the development of regionalized health care delivery systems in rural and urban areas. Services are also expected to be made available to more individuals through achievements in management efficiency, greater productivity and cost effectiveness in ongoing projects.

Efforts to create a regionalized system for the delivery of health care services from the primary care to the tertiary care levels will be focused on pooling health care personnel and supporting services, facilities and technical assistance at the local level, consistent with population needs. These efforts will be carried out in close coordination with the States.

Theme: CAPACITY BUILDING

Objective 1.01 Improve the accessibility and availability of primary health care resources in medically underserved rural and urban areas through the development of 210 new integrated rural and urban community health centers (80 RHI, 20 HURA 10 UHI, 40 HH, 50 AHDP, 10 EDA (516) to reach a target population of 1,060,000 by September 30, 1978.

Central Office Work Activities:

- Develop technical assistance plans and strategies for new rural/urban primary health care projects and training of Regional Office staff and applicant entities for mechanisms of integrating projects

- Provide coordination with BHPRD regarding standards/criteria for project review, identification of priority areas, and technical assistance to Health Systems Agencies

Regional Office Work Activities:

- Develop and implement technical assistance plan for integrating rural/urban projects

  - Identification of priority areas

  - Present program guidance to eligible groups and assist in developing project proposal

  - Review project applications and negotiate changes

  - Fund new integrated community health centers (80 RHI, 20 HURA, 10 UHI, and 40 HH, 50 AHDP, 10 EDA (516)

  - Assure all projects have developed effective working relationships with health systems agencies

Objective 1.02: Develop and implement linkage/integration of 20% of all RHI, HURA, UHI, MH, CHC, NHSC, AIIDP, and EDA grantees with ADAMHA, Medicaid-EPSDT, Emergency Medical Services programs, Title V Programs of Projects, Title X programs or WIC, as appropriate, by September 30, 1978

Central Office Work Activities:

- Develop guidance materials including model linkage/integration packet for ADAMHA, Medicaid-EPSDT, Emergency Medical Services programs, Title V Programs of Projects, and WIC
- Hold workshops in each Regional Office to discuss development and implementation of linkage/integration strategy
- Participate in National Advisory Committee for WIC

Regional Office Work Activities:

- Provide Regional Office review and comment on guidance materials
- Provide technical assistance to BCHS projects to improve programmatic linkages/integration
- Establish linkages/integration of 20% of all RHI, HURA, UHI, MH, CHC, NHSC, AIIDP and EDA projects with ADAMHA, Medicaid-EPSDT, EMS, MCH, FP or WIC

Objective 1.03 Develop positive programming plans to assist in establishing integrated community health centers in 50 States in 10 Regions with priority given to the high risk groups in accord with Child Health Strategy by September 30, 1978

Central Office Work Activities:

- Provide data analysis capability
- Establish priority areas by Region and State using need indicator criteria (e.g., MUA, HSMA, HIMA, HMIA/HIA, High Fertility Area (HFA)).
- Develop protocol for Regions to implement individual State positive programming plans
- Identify resources available by programs
- Define criteria for allocating resources to Regions
- Allocate resources to Regions

Regional Office Work Activities:

- Identify priority areas using indicator criteria (e.g., MUA, HMSA, HIMA, HMIA/HIA, HFA, etc.)
- Identify resources needed
- Define criteria for allocating resources to States
- Allocate resources to States
- Establish State-specific Positive Programming Plan to assure:
  - Involvement of appropriate State agencies
  - Development of family-oriented primary care that appropriately integrates Services of Titles V, X, XX, and other State-controlled Federal programs and linkages with secondary and tertiary levels of care
  - Broadly representative community involvement in developing community programs
  - An agreed upon coordinating point in the State
  - Allocation of State and local resources, including funds and TA

- Time - specific completion of activities
- Conformance with Regional programming priorities
- Development of grant applications consistent with Regional funding cycles
- Review and award of grants consistent with project quality and consistency with the Positive Programming Plan

Objective 1.04 Develop and implement a program to recruit and place 550 additional NHSC professionals in areas of need and make referrals of 1280 health care personnel through the National Manpower Clearinghouse to BCHS funded projects by September 30, 1978

Sub-objective 1 Recruit and place 550 additional NHSC professionals in areas of need, including MUAs, HMSAs, HMIA/HIAs, HIMAs, HFAs, with priority given to filling vacancies in existing BCHS community health centers located in HMSAs

Central Office Activities:

- Collect and analyze data to be included in the annual report to Congress in NHSC
- Review new criteria for designation of health manpower shortage areas (P.L. 94-484) by December 31, 1977
- Conduct media recruitment program in selected journals
- Develop and present advocacy program on campuses
- Conduct direct mail recruitment
- Recruit at professional conferences
- Recruit through NHSC alumni
- Respond to 30,000 requests for information on the NHSC, IHS, and BMS programs
- Coordinate physician extender program with HRA.
- Review and revise Community Policy Manual, Assignee Policy Manual and Memorandum of Agreement

Regional Office Activities:

- Contact and follow-up potential applicants
- Travel potential assignees to communities
- Initiate personnel actions on Civil Service professionals committed to sites
- Provide pre-operational T/A and orientation for assignees

Sub-objective 2 Increase to 45% the number of NHSC physicians retained in either the NHSC or in the community as a practitioner

Central Office Activities:

- Develop materials for communities in recruitment
- Initiate program to offer financial incentives to remain in community
- Train recruiters

Regional Office Activities:

- Reduce number of single NHSC provider sites by 25% by increasing the number of physicians approved per site to a minimum of two and converting single provider sites to nurse practitioner satellite stations to multiple provider group centers
- Achieve and maintain 70% board-eligible physicians in the Corps by emphasizing recruitment of house officers and board-eligible practitioners
- Coordinate NHSC audio-visual training system that provides (a) a circulating video/tape series to NHSC assignees (b) and index of video/tapes available on request to NHSC sites

Sub-objective 3 Develop 50 additional NHSC sites for placement of NHSC professionals

Central Office Activities:

- Develop and monitor loans to communities via loan agreements to sites and provide practice agreements.
- Provide for technical assistance through contracts
- Establish policies for evaluating need for reassignment of NHSC personnel to a site

Regional Office Activities:

- Approve 50 communities for placement of NHSC personnel in NHSC sites. (Working through the National Association of Counties, CHP agencies, and Regional staff, respond to requests for designation and, where appropriate, assist in the development of acceptable applications for placement of personnel and follow-up through the approval stage).
- Review unstaffed sites and revise staffing priorities, if indicated.

- Provide startup funds for new sites. (Utilizing the purchase order or loan mechanisms, the Corps will provide funds to assist communities to establish a practice which will enable Corps placement of personnel).

- Provide technical assistance and information to entities to apply for NHSC personnel and technical assistance with respect to retention of NHSC assignees in HMSA's.

- Evaluate continuing need for reassignment of NHSC personnel to a site.

- Monitor BCRR financial statements, edit reports and obtain corrected reports from sites.

- Assist communities to improve recruitment and enhance placement

Sub-objective 4 Refer 1280 health care professionals through the National Manpower Clearinghouse recruitment efforts for BCHS funded projects

Central Office Activities:

- Conduct recruitment program

- Respond to requests for information

- Refer interested applicants to projects

- Develop cooperative efforts for training manpower in BCHS projects utilizing CETA resources.

Regional Office Activities:

- Maintain contact with BCHS grant-supported activities to determine project needs

Objective 1.05 Increase calendar year 1977 users in all ongoing BCHS projects (subject to BCRR) by 10% to 15% as measured by the increase of calendar year 1977 users over calendar year 1976 users:

Sub-objective 1 Fund and monitor 976* BCHS ambulatory health care projects and 227 Family Planning grantees so that all projects will be in compliance with funding criteria and program indicators.

Central Office Activities:

- Develop legislative specification for P.L. 94-63 by Noveber 30, 1977

  Revise program regulations and develop program guidelines by March 31, 1978

  . Publish Program Regs

    NHSC
    HH Training
    314(d)
    Sec. 516
    Appalachia
    Title XVI (SSI)

  . Publish Program Guidance
    NHSC
    HH
    MCH/CC
    CHC
    MH
    314(d)
    Genetic Disease
    Sec. 516
    Appalachia
    Title XVI

- Develop 314(d) program guidance for directing 314(d) resources to be utilized in primary care capacity building activities of BCHS by December 31, 1977

- Review and revise, if necessary, Funding Criteria and Program Indicators for FY 1978 by October 81, 1977

- Review and revise BCHS Common Reporting Requirements by October 31, 1977

- Monitor compliance of projects with BCRR

Includes 140 AHDP, 345 CHC, 125 MH, 56 HH and 280 NHSC

- Validate and follow-up on operating data systems

Regional Office Activities:

- Review applications
- Award grants
- Monitor accomplishments
- Monitor compliance with program indicators; follow-up with projects to identify causes of non-compliance, and provide assistance to projects in coming into compliance
- Implement revised program regulations and guidelines
- Conduct Project site visits
- Meet with state/local agencies
- Complete development of 138 RHI, 53 HURA 20 UHI and 56 HH projects funded in prior years and those projects funded in FY 77 to become operational by December 31, 1977
- Review and approve 50 State and 6 jurisdiction 314(d) applications to assure satisfactory required documentation and monitor 314(d) applications and provide assistance to direct 314(d) resources for primary care capacity building activities

Sub-objective 2 Develop management and delivery system programs (manuals) for use by health services projects (newly integrated projects as well as on-going projects) to guide and assist their management of project operations by March 31, 1978.

Central Office Activities:

- Develop materials that will be components of a management gudiance manual to improve project performance
- Develop models for patient load system
- Develop models for recordkeeping systems, including registration, appointments and medical records
- Develop models showing innovative approaches to outreach, transportation, and use of physician extenders

- Develop models for billing and collection systems

Regional Office Activities:

Provide Regional Office review and comment

Sub-objective 3 Develop techniques and methodology to assess productivity, cost effectiveness and impact of BCHS health services delivery projects by September 30, 1978

Central Office Activities:

- Conduct trend analysis of program indicators
- Develop and implement standards for cost effectiveness for BCHS funded projects (including comparability of administrative and unit costs and limits for costs for referrals) and conduct trend analysis.
- Reassess FY 1979 Regional allocation formula for BCHS programs targeted to the priority areas of need, high risk groups, and project performance by June 30, 1978

Regional Office Activities:

- Monitor project reporting compliance and follow-up on problems identified to assure compliance
- Provide Regional Office review and comment
- Develop and monitor action plans
- Conduct objective assessment of funding based on priority areas of need, high risk groups, and project performance, etc.

Sub-objective 4 Provide training and technical assistance to ambulatory primary health projects to be in compliance with funding criteria and program indicators by September 30, 1978

Central Office Activities:

- Design training and technical assistance plans and strategies for the following areas:
  - Legislative requirements of community basee governing board (e.g., incorporation processes, by-laws, 501.c(3) status, etc.
  - Facility development

- Budget planning and sound financial management
- Outreach, transportation, use of physician extenders, etc.

- Provide operational assistance through contracts to BCHS-funded projects judged by R.O. to require TA

Regional Office Activities:

- Assess need for training both project and Regional Office staff
- Coordinate provision of training in Regions and monitor training program
- Provide direct operational assistance to projects, sites and States
- Identify need for use of contractual technical assistance to be provided under TA contracts. Coordinate contractor's efforts in Region and provide follow-up.

Sub-objective 5 Maximize non-grant revenue to cover the following national percentage of total operating costs for each of the BCHS programs by September 30, 1978.

	CHC	MH	NHSC*	FP*	AHDP*
National	35%	15%			
Region					
I	30%	5%			
II	44%	20%			
III	40%	7%			
IV	28%	8%			
V	25%	6%			
VI	22%	7%			
VII	23%	6%			
VIII	27%	10%			
IX	32%	25%			
X	26%	16%			

* Targeted percentage to be supplied later, when the analysis of data is completed.

Central Office Activities:

- Monitor policies, procedures and methodologies to improve the ability of BCHS projects to maximize use of third party reimbursement:

- Medicare (prepare protocol for projects to use in assessing whether it would be to their advantage to deal with Medicare on a cost basis. Prepare protocol for projects to use in dealing with carriers).

  - .. Reimbursement of projects on a cost basis
  - .. Compatibility of reporting requirements
  - .. Direct reimbursement
  - .. Reimbursement from area Medicare carrier

- Medicaid reimbursement

  - .. BCHS projects
  - .. Integrated (BCHS, ADAMHA) projects
  - .. Title V/Title XIX Interagency agreements (EPSDT) by Octover 31, 1977

- Title XX agreements with regard to family planning (Titles V and X) and other covered services (Prepare guidelines for projects on how to approach State Title XX agency)

- Uses of direct patient payments

- Special demonstration projects with SRS (Titles XIX and XX) and SSA (Title XVIII)

- Provide guidance to Regions in monitoring and assisting all NHSC operating sites toward financial and operational self-sufficiency

  - Develop appropriate financial management budget limits and reimbursement procedures for Corps that reflect the private practice and group practice models

  - Provide NHSC with capability of reviewing financial management of Corps sites to determine, debt waivers, recomputation of debts, and revision of budget limits and billings of Corps sites.

  - Monitor and analyze Regional Office program outputs, such as designation by Region and State, applications submitted, applications disposition, (i.e., approvals, deferrals, disapprovals) termination of sites, sites going independent.

  - Develop, implement and maintain a mechanism to update changes in Corps site status and reflect these changes in a computerized system.

- Provide training and instructions to Central and Regional Office staff on requirements, policies, procedures and processes of Title XVIII, Title XIX, and Title XX.

- Follow-up of common accounting systems for installation in Bureau programs

- Develop evaluation methodology for review of implementation of accounting system and cost reporting requirements

- Examine current HSF Regulations and Guidelines applicable to BCHS projects for problems experienced in implementing them and modify as appropriate by October 31, 1977.

- Monitor BCHS funded projects for compliance with Health Service Funding Regulations and Guidelines.

  . Analyze general trends by program and by Region for financial plans and BCRR financial data by December 15,1977 (FY77) and December 15, 1978 (FY78)

  . Prepare and disseminate Central Office analysis of financial planning to Regional Offices within 30 days following DMA output of data

- Develop forms for consolidating general and financial plan and grant application by October 31, 1977.

Regional Office Activities:

- Provide Regional Office review and comment on Revised Health Service Funding Regulations and Guidelines and consolidated general/financial plan/grant application forms

- Analyze financial plans submitted with grant applications/continuations

- Develop and monitor action plans

- Assist eligible projects to obtain Medicare reimbursements on a cost basis

- Assist BCHS funded projects not eligible for a direct reimbursement rate with BHI to obtain reimbursement from the area Medicare carrier

- Identify the projects eligible for, but not having agreements with, State Title XX agencies and assist the eligible projects to negotiate and conclude these agreements

- Monitor and assist all NHSC operating sites toward financial and operational self-sufficiency

- Assist all sites in planning for operational self-sufficiency by developing operational budgets, estimations of revenues and target dates for partial and total self-sufficiency

- Assess Title V and Title XIX interagency agreements to determine their impact upon EPSDT and obtain agreement for eligible projects by September 30, 1978.

- Assure that annual CPA audits are conducted for those BCHS programs (CHC, MH) required by the Regulations and encourage other BCHS programs to engage in such audits, as appropriate

Sub-objective 6 Develop facility development plans for acquisition and modernization of health services projects

Central Office Activities:

- Develop guidance to assist projects in their facility planning, including acquisition, A/E agreements, design equipment, and recommended minimum requirements and various mechanisms to acquire capital funds, i.e., Federal construction program assistance (Title XVI of National Health Planning and Resources Development Act, FHA, EDA, etc.)

- Develop information for acquisition and modernization of facilities and acquisition of equipment "packages" for all BCHS health services delivery projects by March 31, 1978

- Assist HRA to complete regulations for ambulatory health care facilities, emphasizing flexibility and simplicity

- Assure inclusion of facility requirements in underserved areas as a part of the positive programming initiative

- Identify and catalogue Federal assistance for construction.
- Produce manual on financing acquisition, construction, renovation, and equipment of facilities

- Establish policy on continued capital funding through depreciation

- Develop guidance on debt funding to enable grantees to estimate its impact on operating costs.

Regional Office Activities:

- Assess the need for new and modernized facilities in BCHS sponsored projects

- Provide TA to assist projects in meeting facility requirements

Objective 1.06 Implement an operational internal quality assessment mechanism for both technical and programmatic quality in all BCHS projects

Sub-objective 1 Implement an operational internal quality assessment mechanism for programmatic quality.

(The Ambulatory Health Care Standards are to be used by projects as a tool for self-assessment of program structure and performance as these should eventually cover all aspects of ambulatory health care. For each standard BCHS plans a detailed guidance further elaborating on the intent of the standard and examples of how it may be met. In addition, suggested protocols for assessing program performance for use by program review committees will be developed. Ambulatory Health Care Standards should be forwarded to all projects. Projects should complete the report as an internal assessment device and forward it to the Regional Office with time-phased plans for corrective action in noncompliance areas).

Central Office Activities:

- Develop standards for dental, nutritional, and social services and continuing professional education for inclusion in Ambulatory Health Care Standards.
- Develop guidances for the above standards to assist projects in achieving compliance.
- Develop protocols for program assessment of performance in the above areas
- Transmit additional standards and protocols to Regional Offices for distribution to projects

Regional Office Activities:

- Transmit additional standards and protocols to projects
- Review assessment reports and plans and provide feedback on their acceptability to projects
- Provide technical assistance to projects in use of standards, guidance and assessment protocols
- Evaluate effectiveness of internal quality assessment of program performance

Sub-objective 2 Implement an operational quality assessment mechanism for technical quality (These are "do-it-yourself" audits which would assist projects in evaluating technical performance)

Central Office Activities:

Develop protocols for assessment of performance in the medical management of diabetics, veneraal disease, family planning services, and two other areas (total six).

- Develop protocols for assessment of nutritional services, radiology services and two others (total four)

- Transmit protocols to R.O. for distribution to projects.

Regional Office Activities:

- Provide technical assistance to projects on use of protocols

- Conduct validation surveys of internal assessment procedures in a minimun of 10% of projects

- Conduct evaluation of protocols as an aid to projects in internal evaluation

Sub-Objective 3 Implement problem-oriented medical record systems in BCHS programs

Central Office Activities:

- Develop strategy for implementing problem-oriented medical systems in BCHS programs

- Establish policy and guidance in utilization of patient record by client

Regional Office Activities:

- Implement strategy, guidance and policy

Objective 1.07 Implement preventive health service activities in all BCHS programs.

The objective is based on the following assumptions:

That the application of scientific advances (e.g., immunization and insulin administration) can contribute to prevention of disease and disability.

That improvements in health status result from changes in behavior and that these behavorial changes are necessary in all age groups along a developmental line from birth to later adulthood.

That the individual, the family and the community have a major responsibility for health maintenance

The first prevention sub-objective recognizes the existence of legislative and administrative barriers to preventive services delivery. Sub-objectives 2 - 3 involve the development of guidance material and models to improve and extend services to specific target population groups and persons with disease conditions. Among the preventive services to be considered during FY 78 are dental health, environmental health, nutrition, vision and hearing, substance abuse, parenting and child abuse, family planning, prenatal care, genetic diseases, mental health, hypertension, abnormal cytology, glaucoma, diabetes and epilepsy. Positive programing offers an opportunity to strengthen preventive health services in communities of greatest need.

Activities relating to preventive health care services for mothers and children will be handled under the Child Health Strategy. However, they will be planned in a coordinated way with all Bureau prevention activities so that preventive health services can be viewed as a continuance throughout the life cycle.

Sub-objective 1 Remove barriers to implementation of preventive services in BCHS programs

Central Office Activities:

- Modify reporting systems to include preventive services
- Modify BCHS Funding Criteria to include preventive services
- Develop recommendations for eliminating legislative and administrative barriers to delivery of preventive services (i.e., third party reimbursement)

Regional Office Activities:

- Implement modifications in funding criteria and reporting requirements

Sub-objective 2 Develop guidance and models for preventive health services

Central Office Activities:

- Develop guidance and models in preventive services:

  Diabetes
  Hypertension
  Epilepsy
  Glaucoma
  Environmental Health

- Provide training to RO staff in implementing gudiance and models

- Evaluate and revise guidance material

- Integrate guidance and models into internal quality of care assessment activities

- Develop criteria on preventive services for RO in reviewing project proposals

Regional Office Activities:

- Review and comment on policy, guidance and models in projects

Sub-objective 3 Implement models of preventive services in 50 BCHS projects

Central Office Activities:

- Provide a data analysis capability to identify areas of need

- Provide technical assistance and training for implementation
- Mointor implementation of models

Regional Office Activities:

- Implement the preventive services models through the positive programming mechanism

- Monitor implementation of models

Sub-objective 4 Develop and implement a nutrition plan in an additional 20% of BCHS service sites.

Central Office Activities:

- Modify guidance material

- Assess overall implementation of nutrition plans

Sub-objective 3 Implement models of preventive services in 50 BCHS projects

Central Office Activities:

- Provide a data analysis capability to identify areas of need
- Provide technical assistance and training for implementation
- Monitor implementation of models

Regional Office Activities:

- Implement the preventive services models through the positive programming mechanism
- Monitor implementation of models

Sub-objective 4 Develop and implement a nutrition plan in an additional 20% of BCHS service sites.

Central Office Activities:

- Modify guidance material
- Assess overall implementation
- Monitor implementation of plans

Regional Office Activities:

- Assist projects to develop and implement nutrition plans
- Monitor implementation of plans

Sub-objective 5 Develop and implement environmental plans in 20% of community health centers, including Migrant Health Projects, which serve agricultural workers

Central Office Activities:

- Develop protocol to assist projects in developing environmental plans
- Review plans with ROs for compliance
- In coorperation with EPA and State health agencies, conduct training programs for project staff in screening, diagnosis and treatment and reporting of pesticide poisoning cases.
- Develop and implement contracts in 4 States to assist State regulatory agencies in coordinating intensified migrant labor camps inspection and code enforcement programs

Regional Office Activities:

- Assist projects to develop environmental plans

Sub-objective 6 Develop and implement preventive services strategies in the following areas of emphasis:

diabetes
hypertension
epilepsy
glaucoma

Central Office Activities:

- Develop strategies

Regional Office Activities:

- Assist in development of strategies
- Implement strategies

CHILD HEALTH

The following objectives and activities have been developed in order to strengthen leadership in maternal and child health at the Federal, Regional, and State levels and develop organized, integrated State-based systems for family-oriented child health* care delivery. The goal is to coordinate, integrate and improve the quality of services for mothers and children and to develop the capacity for leadership in the State, Regional and Central Offices. The first two objectives are targeted on improving the delivery system. Objectives 2.03 to 2.13 are targeted to strengthening and extending specific elements of the Child Health Strategy. The last two objectives deal with research and training activities which support services delivery. Objectives are to be completed by September 30, 1978.

* Child health care includes family planning, prenatal, perinatal, child health and adolescent health services

Objective 2.01 Assure the capacity of the 10 Regional Offices and 56 States and political jurisdictions to develop, implement, and monitor systems of child health care

Central Office Activities:

- Establish administrative policy and procedures to require submission to Regional Office of State Plans for Health Services for mothers and children.

- Develop strategy to assure coordination between State activities concerned with the health of mothers and children and Title V, 93-641, SSI, Title XIX, EPSDT, Title XX, WIC and BCHS projects.

- Supplement the guidance materials in Health Services for Mothers and Children in selected areas, e.g., handicapped, etc.

- Develop guidance for linking SCDP clinics with other genetic disease screening education clinics and MCH/CC programs

Regional Office Activities:

- Review and approve all State plans

- Provide consultation/TA to State personnel to develop and implement the State plan, e.g., site visits, regional/bi-regional conferences, guidance, contracts, etc.

- Review BCHS program/project applications to assure that family oriented health services for mothers and children are identified in all BCHS projects (linkages, coordination, agreements).

Objective 2.02 Develop and implement organized State-based systems for Child Health Care delivery in 10 States.

Central Office Activities:

- Develop guidance on developing State-based systems
- Establish criteria for selection of States
- Develop a model for consolidation of MCH services in the States

Regional Office Activities:

- Adapt the model to the selected State
- Assist the States in implementing the model
- Monitor the activity

Objective 2.03 Increase the number of persons*in BCHS programs/projects receiving quality family planning services (as defined in BCHS standards) by the following percentages:

adolescents - 15%
high risk women - 10%
other persons in need - 15%
*(Persons will be measured as users in BCRR)

Central Office Activities:

- Develop guidance and procedures for implementation, including a system for identifying and following up high risk use.
- Develop a strategy to implement quality family planning services in an additional 250 BCHS projects
- Implement an expanded information and education campaign focusing on teenagers, males and other high-risk or hard to reach groups
  - Expand the National Clearinghouse for Family Planning information
  - Conduct 4 Regional Conferences in teenagers and family planning
  - Develop and demonstrate educational modules for teenage clients
  - Conduct media campaign directed toward teenagers and males

Regional Office Activities:

- Assist the projects in implementation of guidance
- Assess/monitor progress
- Implement a strategy to institute quality family planning services in an additional 250 BCHS projects
- Implement an expanded information and education campaign focusing on teenagers, males and other high-risk or hard to reach groups
  - Develop and implement family planning patient education services in 500 BCHS sites
  - Conduct four Regional conferences on teenagers and family planning
  - Develop and disseminate patient education materials to BCHS service projects

Objective 2.04 Increase by 20% the number of women who receive prenatal care in their first trimester in 50 additional BCHS projects (The focus of this objective is to increase the number of women who receive care earlier in their pregnancy)

Central Office Activities:

- Assess FY 77 activities
- Modify and disseminate guidance to ROs
- Monitor FY 78 activities

Regional Office Activities:

- Select 50 additional sites
- Implement the objective in 50 additional sites
- Monitor the activity

Objective 2.05 Increase by 20% the number of women and infants in 13 States having access to quality prenatal and perinatal services

Central Office Activities:

- Stimulate and award continuation grants for IPO program in 13 States
- Conduct a national workshop to assess overall progress, and evaluate IPO effort and identify successful components transferable to other States
- Develop and implement a strategy for improving the quality of services (consultation, workshops, staffing)

Regional Office Activities:

- Stimulate and award continuation grants for Improved Pregnancy Outcome program in 13 States
- Participate in national workshop to assess overall progress
- Stimulate 10 States to initiate or expand the program
- Monitor ongoing programs

Objective 2.06 Improve the availability, accessibility and quality of services to children with handicapping conditions in all states

Central Office Activities:

- Modify current guidance and develop supplemental guidance for implementation
- Identify Federal State-supported services to children with handicapping conditions
- Develop a strategy for coordinating services to those children within the States (CC, Inborn errors, UAF, DD, Education, VR, SSI, XIX, EPSDT, D&E Clinics, etc.) Parents are considered active participants in planning for the delivery of services to the child.

Regional Office Activities:

- Assist in identifying Federal/State supported services for children with handicapping conditions
- Assist in developing the strategy for coordinating services to these children within these states
- Review and monitor State plans for SSI, Genetics

Objective 2.07 Assist all States to develop and extend SIDS services and activities for all families in need of similar support services

Central Office Activities:

- Develop and disseminate guidance for incorporating SIDS and similar services and activities into State plans
- Make SIDS I&E materials available to Regional Offices
- Review, award and monitor 30 SIDS project grants
- Provide consultation to all States regarding information and counseling services and other program areas

Regional Office Activities:

Not applicable

Objective 2.08 Improve dental health services to Head Start children through 56 State MCH Plans

Central Office Activities:

- Renew interagency agreement with OCD
- Develop a strategy to incorporate dental consultation in Head Start through States
- Monitor program progress (reports, meetings, site visits)
- Prepare and disseminate Annual Report

Regional Office Activities:

- Assist in developing a strategy to incorporate dental consultation in Head Start through States
- Provide consultation and technical assistance to each State dental office or unit

Objective 2.09 Improve the quality of child health care provided to infants, preschool and school age children (0-12 years) in all BCHS projects

Central Office Activities:

- Develop and implement strategy to assure that 90% of all two-year-old children currently served by BCHS projects are immunized (include attention to children who have handicapping conditions and are mentally retarded).

- Assist Regional Offices to establish hearing projects in 50 BCHS sites and evaluate impact on early identification and treatment

- Develop a strategy to assure that BCHS projects serving mothers and children are effectively utilizing the resources of the WIC program

Regional Office Activities:

- Implement guidance on assessment of growth and development, dental health, nutrition, vision and hearing in 50 service delivery projects

- Implement strategy to assure that 90% of two-year-old children currently served by BCHS projects are immunized.

- Establish hearing projects in 50 BCHS sites and evaluate impact in early identification and treatment

- Implement a strategy to assure that BCHS projects serving mothers and children are effectively utilizing the resources of WIC program

Provide specialized, clinical consultation and technical assistance to improve the quality of child health supervision in all Migrant Health projects.

Objective 2.10 Improve the vision services to children provided by all BCHS projects in 10 States

Central Office Activities:

- Develop guidance for BCHS projects

Regional Office Activities:

- Select 10 States (1 per Region)
- Identify services in BCHS programs/projects in those 10 States
- Monitor the activity

Objective 2.11 Assist all BCHS programs/projects to provide comprehensive health services to adolescents in 10 States.

Central Office Activities:

- Modify and supplement guidance as necessary
- Continue NACSAP contract in 5 States and disseminate findings to all BCHS programs/projects
- Provide necessary training for health care providers in the 10 States
- Develop and award demonstration grants for model comprehensive health services for adolescents in 10 States
- Develop educational programs on preventive health services and parenthood for adolescents

Regional Office Activities:

- Select 10 States
- Identify services available in State and assess training needs
- Develop and award demonstration grants for model comprehensive health services for adolescents in 10 States

Objective 2.12 Develop___ model programs which provide comprehensive support services to pregnant adolescents, teenage parents and their infants, and thus strengthen family life.

Central Office Activities:

- Develop___ model programs
- Develop guidance
- Develop educational programs which will improve the quality of family life

Regional Office Activities:

- Implement programs and guidance

Objective 2.13 Implement a Genetic Disease Program through 4-30 Genetic Disease Service Grants and 20-24 Sickle Cell Contracts

Central Office Activities:

- Develop and award 20-24 Sickle Cell Contracts
- Develop guidance material for providers (physicians, nurses, counselors, health educators) in screening and education clinics.
- Develop guidance material on personnel qualifications for clinics
- Develop and implement a plan for coordinating and integrating Sickle Cell Disease Screening and Education Clinics, Genetic Disease Programs and BCHS programs
- Monitor and provide technical assistance to existing grants and contracts
- Develop and award 4-30 Genetic Disease Service grants (if funds appropriated)
- Expand amniocentesis services to ___women by _____
- Develop and award 17-20 Hemophelia Grants

Regional Office Activities:

- Stimulate and assist in project development
- Participate in objective review process
- Provide technical assistance to projects
- Monitor implementation

Objective 2.14 Conduct research in delivery of MCH and FP services

Sub-objective 1 Conduct 50 projects in the MCH research program

Central Office Activities:

- Stimulate, fund, and monitor research projects designed to improve services to mothers and children
- Disseminate research findings

Regional Office Activities:

- Assist in review of applications

Sub-objective 2 Implement a research program focusing on reducing barriers to family planning services through development of improved service delivery techniques

Central Office Activities:

- Provide technical assistance to Regional Office staff in implementation of program objectives
- Expand natural family planning services provided in BCHS projects
- Develop and implement strategy for including natural family planning in service programs
- Conduct four Regional conferences on natural family planning and fertility awareness
- Improve the NRSFPS and grantee data management activity
- Provide technical assistance to data systems reporting to NRSFPS
- Implement NRSFPS sample survey
- Complete statistical analyses for Five Year Plan
- Demonstrate alternative approaches for providing family planning services to teens and males

Regional Office Activities:

- Provide technical assistance to project staff in implementing program objectives
- Participate in regional conferences in national family planning and fertility awareness

Objective 2.15 Conduct training of specialized personnel

Sub-objective 1 Conduct 160 projects in the training program for MCH to provide specially trained personnel for leadership in MCH services

Central Office Activities:

- Stimulate, fund, and monitor training projects
- Coordinate BCHS training activities with HSA and other PHS training programs

Regional Office Activities:

- Assist in review of training proposals

Sub-objective 2 Increase the number of family planning workers trained by 10 percent

Central Office Activities:

- Develop and implement Title X training program
- Develop guidance for and approve Regional training plans
- Complete 10 awards for Regional training projects
- Assess performance of projects through site visits and reporting
- Provide technical assistance to RPC's and training projects
- Develop and implement five nurse practitioner training programs that cover the 10 regions
- Conduct two national training conferences

Regional Office Activities:

- Implement the findings of the manpower assessment project

Sub-objective 3 Increase the number of nutrition manpower trained by graduate level by 150%

Central Office Activities:

- Develop 3 new graduate training programs in Universities
- Expand 5 existing graduate programs to support more trainees

Regional Office Activities:

- Assist in placement of trainees receiving BHM/NHSC scholarships and Title V/MCH support

(B) the effect on the health of such workers of deficiencies in their housing conditions during such period; and

(C) Federal, State, and local government standards respecting housing conditions for such workers during such period and the adequacy of the enforcement of such standards.

In conducting or arranging for the conduct of such study, the Secretary shall consult with the Secretary of Housing and Urban Development.

(2) Such study shall be completed and a report detailing the findings of the study and the recommendations of the Secretary for Federal action (including legislation) respecting such housing conditions shall be submitted to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate within eighteen months of the date of the enactment of the first Act making appropriations for such study. Report to congressional committees.

TITLE V—COMMUNITY HEALTH CENTERS

COMMUNITY HEALTH CENTERS

SEC. 501. (a) Part C of title III of the Public Health Service Act is amended by adding after section 329 the following new section:

"COMMUNITY HEALTH CENTERS

"SEC. 330. (a) For purposes of this section, the term 'community health center' means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides— Definitions. 42 USC 254c.

"(1) primarily health services,

"(2) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

"(3) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

"(4) as may be appropriate for particular centers, environmental health services, and

"(5) information on the availability and proper use of health services,

for all residents of the area it serves (referred to in this section as a 'catchment area').

"(b) For purposes of this section:

"(1) The term 'primary health services' means—

"(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

"(B) diagnostic laboratory and radiologic services;

"(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

"(D) emergency medical services;

"(E) transportation services as required for adequate patient care; and

"(F) preventive dental services.

"(2) The term 'supplemental health services' means services which are not included as primary health services and which are—

"(A) hospital services;

"(B) home health services;

"(C) extended care facility services;

"(D) rehabilitative services (including physical therapy) and long-term physical medicine;

"(E) mental health services;

"(F) dental services;

"(G) vision services;

"(H) allied health services;

"(I) pharmaceutical services;

"(J) therapeutic radiologic services;

"(K) public health services (including nutrition education and social services);

"(L) health education services; and

"(M) services which promote and facilitate optimal use of primary health services and the services referred to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a community health center are of limited English-speaking ability, the services of outreach workers fluent in the language spoken by a predominant number of such individuals.

"(3) The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

Grants.

"(c)(1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

"(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

"(B) the design of a community health center program for such population based on such assessment;

"(C) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

"(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

"(2) Not more than two grants may be made under this subsection for the same project.

"(3) the amount of any grant made under this subsection for any project shall be determined by the Secretary.

Grants.

"(d)(1)(A) The Secretary may make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations.

"(B) The Secretary may make grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which he is unable to make each of the determinations required by subsection (e)(2).

"(2) The costs for which a grant may be made under paragraph (1) may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying interest on, loans) and the costs of providing training related to the provision of primary health services, supplemental health services and environmental health services, and to the management of community health center programs.

"(3) Not more than two grants may be made under paragraph (1)(B) for the same entity.

"(4) The amount of any grant made under paragraph (1) shall be determined by the Secretary.

"(e)(1) No grant may be made under subsection (e) or (d) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary— Application.

"(A) a description of the site of the building,

"(B) plans and specifications for its modernization, and

"(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176, 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

"(2) Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—

"(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

"(B) the center will have organizational arrangements, established in accordance with regulations prescribed by the Secretary, or (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

"(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

"(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement; 42 USC 1396.

"(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

42 USC 1395.
42 USC 1396.

Fee schedule.

"(F) the center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

Governing board.

"(G) the center has established a governing board which (i) is composed of individuals a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) meets at least once a month, establishes general policies for the center (including the selection of services to be provided by the center and a schedule of hours during which services will be provided), approves the center's annual budget, and approves the selection of a director for the center;

"(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, and (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require;

42 USC 1395x.

Review.

"(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

Limited English-speaking individuals.

"(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for

providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

"(f) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a community health center, and in meeting requirements of subsection (e)(2).

"(g)(1) There are authorized to be appropriated for payments pursuant to grants under subsection (c) $5,000,000 for fiscal year 1976, and $5,000,000 for fiscal year 1977. Appropriation authorization.

"(2) There are authorized to be appropriated for payments pursuant to grants under subsection (d) $215,000,000 for fiscal year 1976, and $235,000,000 for fiscal year 1977.".

(b) Section 314(e) of the Public Health Service Act is repealed. Repeal. 42 USC 246.

TITLE VI—MISCELLANEOUS

DISEASES BORNE BY RODENTS

SEC. 601. (a) Section 317(h)(1) of the Public Health Service Act is amended by striking out "and RH disease" and inserting in lieu thereof ", RH disease, and diseases borne by rodents". 42 USC 247b.

(b) Section 317(d)(3) of such Act is amended by adding at the end thereof the following: "There is authorized to be appropriated for fiscal year 1976 $20,000,000 for grants under this section for communicable and other disease control programs for diseases borne by rodents.". Appropriation authorization.

HOME HEALTH SERVICES

SEC. 602. (a)(1) For the purpose of demonstrating the establishment and initial operation of public and nonprofit private agencies (as defined in section 1861(o) of the Social Security Act) which will provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary of Health, Education, and Welfare may, in accordance with the provisions of this section, make grants to meet the initial costs of establishing and operating such agencies and expanding the services available through existing agencies, and to meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services of existing agencies. Grants. 42 USC 1395x note. 42 USC 1395x.

(2) In making grants under this subsection, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas within a State in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

(3) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall prescribe by regulation. Application.

federal register

FRIDAY, DECEMBER 3, 1976

PART II:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

■

COMMUNITY HEALTH SERVICES

Grants

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER D—GRANTS

PART 51c—GRANTS FOR COMMUNITY HEALTH SERVICES

Final Regulations

On June 11, 1976, interim regulations implementing section 330 of the Public Health Service Act (42 U.S.C. 254c) were published in the FEDERAL REGISTER (41 FR 23852). The regulations adopted a new Part 51c of Title 42, Code of Federal Regulations, and Subparts A through D thereof, establishing program requirements applicable to grants for community health services projects under section 330. Although the regulations were effective upon publication, the Secretary invited public comment on the regulations and indicated that they would be revised as warranted by the comments received. Thirty-five letters offering substantive comments were received in response to this invitation, and all comments have been considered. A summary of the comments received and of the actions taken pursuant to those comments is set forth below.

1. One comment held that it was unrealistic to expect a community health center to serve all residents of its catchment area, as required by the definition of community health center in § 51c.102 (c) (1), and suggested that the word "all" be deleted. This suggestion was not followed, as the provision by a center of services for "all residents" of a center's catchment area is required by Section 330(a) of the Act. It is noted this provision requires that all residents of a center's catchment area be eligible for service on an equal basis.

2. A number of comments suggested that certain supplemental health services be made primary health services or that other services be added to the list of primary health services. Two comments noted that the definitions of primary and supplemental health services are not consistent with the definitions applicable to health maintenance organizations under title XIII of the Act, and stated that this would preclude an entity from being funded under both authorities. However, except as noted below, no change was made, since what comprises "primary health services" and "supplemental health services" is specified by the statute. It should also be noted that the different definitions in title XIII and section 330 will not preclude funding under both authorities, since where a service is required as a primary health service under title XIII but not under section 330, it may be provided as a supplemental health service under section 330. In such a situation, therefore, where the service in question is offered, the requirements of both authorities would be met.

3. The suggestion that the definition of "physician" in § 51c.102(g) be revised to include optometrists and podiatrists has been rejected as their inclusion in the definition would not accord with the traditional usage of the term in the Act and related provisions of law. However, it should be noted that where a center's primary or supplemental health services are provided by optometrists or podiatrists in accordance with applicable requirements, the provision of such services would be eligible for support by the center.

4. A number of comments suggested that certain primary and supplemental health services be expanded to include or name specific services. Some of these suggestions have been accepted and some rejected, as follows:

a. Two comments recommended the addition of other specific professions to those enumerated in § 51c.102(h)(1), on the ground that such professions would otherwise be excluded. However, since the professions listed are examples only and not an exclusive list and thus would not exclude related professions, it was considered unnecessary to revise the provision.

b. Several comments advocated including certain additional services on the list (§ 51c.102(h)(3)) of preventive health services to be provided. These suggestions have been followed.

c. It was suggested that the definitions in § 51c.102(j) (2), (4) and (11) be expanded to include homemaker services. The statute specifically includes "home health services" but does not refer to homemaker services. It is therefore reasonable to assume that Congress did not intend to include such services in its enactment of section 330.

d. One comment urged that the list of preventive dental services required under § 51c.102(h)(6) be expanded to include restoration, extraction and prosthetic work. This suggestion has not been followed, since such services are included in dental services under supplemental health services (see § 51c.102(j)(6)).

5. One comment recommended that Indian organizations specifically be made eligible to apply for grants in § 51c.103. Since eligibility for grants is established by the statutory language, this recommendation has not been adopted. However, it should be noted that Indian organizations which are "public or nonprofit private entities" would by definition be eligible to apply for grants.

6. One comment objected to using the catchment area concept to determine eligibility for care and basing the determination of a catchment area on the geographic criteria set out in § 51c.104 (b)(2). However, since this approach is mandated by the statute (sections 330 (a), 330(e)(2)(D)), no change was made.

7. Two comments recommended that public accountants as well as certified public accountants be authorized to perform the audit required under § 51c.104 (b)(6) and § 51c.303(d). This matter was carefully reviewed and the regulation was revised in accordance with policies of the Comptroller General of the United States in this regard.

8. Two comments requested that the requirements of § 51c.105 be expanded to include review by State and local agencies not part of the review process under Title XV of the Act. The Secretary does not have the authority under section 330 to impose additional review duties on State and local agencies, but where additional State and local review is required by State and local law, section 330 applicants are of course subject to those requirements. Thus, to the extent that the comments urged imposition of review requirements not present under State or local law, the suggestions have been rejected as unauthorized and, to the extent they suggested compliance with State and local laws which are applicable by their own terms, the suggestions have been rejected as unnecessary.

9. One comment questioned what § 51c.105 requires where the local health systems agency (HSA) is not yet operational. In such a case, the requirements of Title XV of the Act with respect to the review and approval responsibilities assigned to the appropriate health planning agency designated under title XV are applicable only after such agency has been designated and is authorized to perform such review and approval functions.

10. Six comments objected to the provision in Subparts B, C, and D that grants may be made only to entities which will serve a "medically underserved population". The comments, however, did not relate to the provisions of the regulation per se but rather to the expected implementation of the provision based on experience under title XIII. Five comments pointed out that use of health resources statistics excludes "poverty pockets" with a paucity of health resources within large counties, while two stated that use of home addresses in computing physician-population ratios does not necessarily indicate proximity of medical care. However, the regulation does not preclude consideration of poverty pockets in designating areas of medical underservice. The Secretary is in the process of establishing procedures to enable special circumstances creating medical underservice to be taken into account.

11. Expansion of the factors considered under § 51c.102(e) (1) and (4) in determining what constitutes a "medically underserved population" was also recommended. It should be noted, though, that the factors listed are not an exclusive list. In addition, it was felt that experience with substantially the same criteria under Title XIII of the Act has shown their viability and hence they should be retained unchanged.

12. One comment objected that the peer review requirement of § 51c.303(c) was process rather than outcome-oriented and that the organizational arrangements required might be inappropriate in particular cases. It should be noted, however, that the statutory requirement that the regulations set requirements for the "organizational arrangements" for peer review implies process rather than outcome-oriented criteria. In addition, it was felt that too little is presently known about how to formulate desirable outcomes in an ambulatory care setting to enable meaning-

ful outcome-oriented criteria to be established. It was also felt that the requirements as written contain sufficient flexibility to permit a variety of appropriate organizational arrangements. Accordingly, no change was made.

13. Several comments objected to the ceiling on discounts in § 51c.303(f) of 200 percent of the poverty level, on the grounds that it would constitute a barrier to service for persons with incomes in excess of the level and that a negotiated fee schedule would improve collections and generally be more administratively viable. However, the 200-percent ceiling has been retained on several grounds. First, it reflects current practice in a number of ambulatory health care projects funded under the Public Health Service Act. Also, it is considered to be reasonable in light of the goals of the program; specifically, the ceiling of 200 percent of poverty guidelines on discounts provides considerable leeway above the poverty guideline for utilizing discounts and is higher than the average income of lower budget families, as determined by the Bureau of Labor Statistics of the Department of Labor. Finally, it is considered to be more administratively practical than a negotiated fee schedule system, as it will require only periodic determinations of income rather than individual determinations for each kind of service provided.

In view of the concern expressed with the alteration in charging practices entailed by the regulations, however, the section has been changed to permit the imposition of a nominal charge for services even where the patient would otherwise receive a full discount.

14. One comment urged that § 51c.303(p) be revised to spell out staff qualifications more completely and that the minimum for such qualifications be set high. However, since the composition of the professional staff of various projects will probably vary widely depending on the types of services provided, this suggestion was considered not to be feasible and was not adopted.

15. Fourteen comments objected to various provisions applicable to the governing board requirement of § 51c.304. The comments, and the actions taken in response to them, are summarized below.

a. Most of the comments objected to the requirement of § 51c.304(b)(1) that a majority of the board be composed of individuals who are or will be served by the center and who, as a group, are representative of such individuals. Elimination or provision for waiver of this section was advocated. However, the requirement is a statutory one (section 330(e)(2)(G)(i)), and accordingly the Secretary has no legal authority to remove or waive it.

b. Several comments objected to the size limitations of § 51c.304(a) on the grounds that smaller or larger boards had in particular cases been found to be workable. Accordingly, appropriate provision for waiver has been included.

c. Two comments objected to the restrictions of § 51c.304(b)(2) and (4). One requested a revision to allow a relative of a board member to be an employee of the center. Another recommended that the regulation be revised to allow for the involvement of center physicians and administrators in governing board decision-making. However, it was felt that allowing relatives of board members to be employees of the center would create conflicts of interest contrary to good management. Also, center physicians and administrators can either be represented by the project director, who may be a non-voting, ex-officio member of the board, or be invited to meet with the board and to be as involved as the board of directors may wish. Accordingly, these suggestions have not been followed.

16. Several comments objected to the requirement in § 51c.403(a) that community health projects funded under Subpart D must meet all of the requirements for a community health center except for those dealing with the governing board, as more restrictive than the law. This requirement reflects an administrative judgment that these requirements constitute a reasonable minimum set of requirements for the provision of quality health services and the establishment of viable organizations, and hence has been retained.

17. In addition to the above, minor technical and clarifying changes have been made.

In consideration of the foregoing, the Assistant Secretary for Health of the Department of Health, Education, and Welfare, with the approval of the Secretary of Health, Education, and Welfare, hereby revises Subparts A through D of Part 51c of Title 42, Code of Federal Regulations, as set forth below, effective as of December 3, 1976.

It is hereby certified that the economic and inflationary impacts of this regulation have been carefully evaluated in accordance with Executive Order 11821.

Dated: October 21, 1976.

JAMES F. DICKSON,
Acting Assistant Secretary for Health.

Approved: November 23, 1976.

MARJORIE LYNCH,
Acting Secretary.

Subpart A—General Provisions

AUTHORITY: Secs. 215, 330, Public Health Service Act (42 U.S.C. 216, 254c).

Subpart A—General Provisions

§ 51c.101 Applicability.

The regulations of this subpart are applicable to all project grants authorized by section 330 of the Public Health Service Act (42 U.S.C. 254c).

§ 51c.102 Definitions.

As used in this part:

(a) "Act" means the Public Health Service Act.

(b) "Catchment area" means the area served by a project funded under section 330 of the Act.

(c)(1) "Community health center" or "center" means an entity which, through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities, provides for all residents of its catchment area:

(i) Primary health services;

(ii) As determined by the Secretary to be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services;

(iii) Referral to providers of supplemental health services and payment, as determined by the Secretary to be appropriate and feasible, for their provision of such services;

(iv) Environmental health services, as determined by the Secretary to be appropriate for particular centers; and

(v) Information on the availability and proper use of health services.

(2) For purpose of paragraph (c)(1) of this section, the provision of a given service by a center will be determined by the Secretary to be appropriate where

(i) There is a need, as determined by the Secretary, for the provision of such service in the catchment area; and

(ii) The provision of such service by the center is feasible, taking into consideration the center's projected revenues, other resources, and grant support under this part.

(d) "Environmental health services" means the detection and alleviation of unhealthful conditions of the environment of the catchment area, such as problems associated with water supply, sewage treatment, solid waste disposal, rodent and parasite infestation, and housing conditions. For the purposes of this part, the detection and alleviation of unhealthful conditions of the environment includes the notification of and making of arrangements with appropriate Federal, State, or local authorities

responsible for correcting such conditions.

(e) "Medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Medically underserved areas will be designated by the Secretary and a list of those designated will be published in the FEDERAL REGISTER from time to time, taking into consideration the following factors, among others:

(1) Available health resources in relation to size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to population;

(2) Health indices for the population of the area, such as infant mortality rate;

(3) Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and

(4) Demographic factors affecting the population's need and demand for health services, such as percentage of the population age 65 and over.

(f) "Nonprofit," as applied to any private agency, institution, or organization, means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(g) "Physician" means a licensed doctor of medicine or doctor of osteopathy.

(h) "Primary health services" means:

(1) Diagnostic, treatment, consultative, referral, and other services rendered by physicians, and, where feasible, by physicians' extenders, such as physicians' assistants, nurse clinicians, and nurse practitioners;

(2) Diagnostic laboratory services and diagnostic radiologic services;

(3) Preventive health services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post-partum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services;

(4) Emergency medical services, including provision, through clearly defined arrangements, for access of users of the center to health care for medical emergencies during and after the center's regularly scheduled hours;

(5) Transportation services as needed for adequate patient care, sufficient so that residents of the catchment area served by the center with special difficulties of access to services provided by the center receive such services; and

(6) Preventive dental services provided by a licensed dentist or other qualified personnel, including (i) oral hygiene instruction; (ii) oral prophylaxis, as necessary; and (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply.

(i) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(j) "Supplemental health services" means health services which are not included as primary health services and which are:

(1) Inpatient and outpatient hospital services;

(2) Home health services;

(3) Extended care facility services;

(4) Rehabilitative services (including physical and occupational therapy) and long-term physical medicine;

(5) Mental health services, including services of psychiatrists, psychologists, and other appropriate mental health professionals;

(6) Dental services other than those provided as primary health services;

(7) Vision services, including routine eye and vision examinations and provision of eyeglasses, as appropriate and feasible;

(8) Allied health services;

(9) Pharmaceutical services, including the provision of prescription drugs;

(10) Therapeutic radiologic services;

(11) Public health services (including nutrition education and social services);

(12) Ambulatory surgical services;

(13) Health education services; and

(14) Services, including the services of outreach workers, which promote and facilitate optimal use of primary health services and services referred to in the preceding subparagraphs of this paragraph and, if a substantial number of individuals in the population served by the center are of limited English-speaking ability, the services of outreach workers and other personnel fluent in the language or languages spoken by such individuals.

§ 51c.103 Eligibility.

Any public or nonprofit private entity is eligible to apply for a grant under this part.

§ 51c.104 Application.

(a) An application for a grant under this part shall be submitted to the Secretary at such time and in such form and manner as the Secretary may prescribe.

(b) The application shall contain a budget and narrative plan of the manner in which the applicant intends to conduct the project and carry out the requirements of this part. The application must describe how and the extent to which the project has met, or plans to meet, each of the requirements in Subpart B (relating to grants for planning and developing community health centers), Subpart C (relating to grants for the operation of community health centers), or Subpart D (relating to grants for the operation of community health projects), as applicable. In addition, applications must include:

(1) A statement of specific, measurable objectives and the methods to be used to assess the achievement of the objectives in specified time periods and at least on an annual basis.

(2) The precise boundaries of the catchment area to be served by the applicant, including an identification of the medically underserved population or populations within the catchment area. In addition, the application shall include information sufficient to enable the Secretary to determine that the applicant's catchment area meets the following criteria:

(i) The size of such area is such that the services to be provided by the applicant are available and accessible to the residents of the area promptly and as appropriate;

(ii) The boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and

(iii) The boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

(3) The results of an assessment of the need that the population served or proposed to be served has for the services to be provided by the project (or in the case of applications for planning and development projects, the methods to be used in assessing such need), utilizing, but not limited to, the factors set forth in § 51c.102(e)(1)–(4).

(4) Position descriptions for key personnel who will be utilized in carrying out the activities of the project and a statement indicating the need for the positions to be supported with grant funds to accomplish the objectives of the project.

(5) Letters and other forms of evidence showing that efforts have been made to secure financial and professional assistance and support for the project within the proposed catchment area and the continuing involvement of the community in the development and operation of the project.

(6) An assurance that an independent certified public accountant, or a public accountant licensed before December 31, 1970, will be engaged to certify that the system for the management and control of its financial assets will be in accord with sound financial management practices, including applicable Federal requirements.

(7) A list of all services proposed to be provided by the project.

(8) A list of services which are to be provided directly by the project through its own staff and resources and a description of any contractual or other arrangements (including copies of documents, where available) entered into, or planned for the provision of services.

(9) The schedule of fees and/or payments and schedule of discounts for services provided by the project.

(10) Evidence that:

(i) The requirements of Part I of Office of Management and Budget Circular No. A-95 have been satisfied, and

(ii) All applicable requirements for review and/or approval of the application under Title XV of the Act have been met.

(11) An assurance that the project will be conducted in accordance with the applicable requirements of this part.

(c) The application must be executed by an individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the statute, the applicable regulations of this part, and any additional conditions of the grant.

§ 51c.105 Accord with health planning.

A grant may be made under this part only if the applicable requirements of title XV of the Act relating to review and approval by the appropriate health planning agencies have been met.

§ 51c.106 Amount of grant.

(a) The amount of any award under this part will be determined by the Secretary on the basis of his estimate of the sum necessary for a designated portion of direct project costs plus an additional amount for indirect costs, if any, which will be calculated by the Secretary either:

(1) On the basis of the estimate of the actual indirect costs reasonably related to the project; or

(2) On the basis of a percentage of all, or a portion of, the estimated direct costs of the project when there are reasonable assurances that the use of such percentage will not exceed the approximate actual indirect costs. Such award may include an estimated provisional amount for indirect costs or for designated direct costs (such as fringe benefit rates) subject to upward (within the limits of available funds) as well as downward adjustments to actual costs when the amount properly expended by the grantee for provisional items has been determined by the Secretary: *Provided, however,* That no grant shall be made for an amount in excess of the total cost found necessary by the Secretary to carry out the project.

(i) In determining the percentage of project costs to be borne by the grantee, factors which the Secretary will take into consideration will include the following:

(A) The ability of the grantee to finance its share of project costs from non-Federal sources;

(B) The need in the area served by the project for the services to be provided; and

(C) The extent to which the project will provide services in an innovative manner which the Secretary desires to stimulate in the interest of developing more effective health service delivery systems on a regional or national basis.

(ii) At any time after approval of an application under this part, the Secretary may retroactively agree to a percentage of project costs to be borne by the grantee lower than that determined pursuant to paragraph (a) (2) (i) of this section where he finds that changed circumstances justify a smaller contribution.

(iii) In determining the grantee's share of project costs, costs borne by Federal grant funds, or costs used to match other Federal grants, may not be included except as otherwise provided by law or regulations.

(b) All grant awards shall be in writing, and shall set forth the amount of funds granted and the period for which support is recommended.

(c) Neither the approval of any project nor any grant award shall commit or obligate the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved project or portion thereof. For continuation support, grantees must make separate application.

§ 51c.107 Use of project funds.

(a) Any funds granted pursuant to this part, as well as other funds to be used in performance of the approved project, may be expended solely for carrying out the approved project in accordance with section 330 of the Act, the applicable regulations of this part, the terms and conditions of the award, and the applicable cost principles prescribed in Subpart Q of 45 CFR Part 74.

(b) Project funds awarded under this part may be used for, but need not be limited to, the following:

(1) The costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying interest on, loans), but only in accordance with subpart E of this part and as approved in the grant award;

(2) The costs of obtaining technical assistance to develop and improve the management capability of the project, but only as approved by the Secretary;

(3) The reimbursement of members of the grantee's governing board, if any, for reasonable expenses actually incurred by reason of their participation in board activities;

(4) The reimbursement of governing board members for wages lost by reason of participation in the activities of such board if the member is from a family with an annual family income below $10,000 or if the member is a single person with an annual income below $7,000;

(5) The cost of delivering health services, including services rendered on a prepaid capitation basis, to residents of the project's catchment area within the following limitations: grant funds may be used to pay the full cost of project services to individuals and families with annual incomes at or below those set forth in the most recent "OSA Income Poverty Guidelines" (45 CFR 1060.2) issued by the Community Services Administration; and to pay the portion of the cost of services provided in accordance with the schedule of discounts which, under such schedule, is uncompensated; *Provided,* That (i) charges will be made to such individuals and families in accordance with § 51c.-303(f) of Subpart C; (ii) reasonable effort shall be made to collect such charges under a billing and collections system; and (iii) the charge to grant funds shall exclude any amounts collected pursuant to paragraph (b) (5) (ii) of this section;

(6) The cost of insurance for medical emergency and out-of-area coverage;

(7) The cost of providing to the staff of the project training related to the provision of health services provided or to be provided by the project, and, to the staff and governing board, if any, training related to the management of an ambulatory care facility, consistent with the applicable requirements of 45 CFR Part 74; and

(8) The cost of developing and maintaining a reserve fund where required by State law for prepaid health care plans.

(c) Prior approval by the Secretary of revisions of the budget and project plan is required whenever there is to be a significant change in the scope or nature of project activities.

§ 51c.108 Grant payments.

The Secretary shall from time to time make payments to a grantee of all or a portion of any grant award, either in advance or by way of reimbursement for expenses incurred or to be incurred, to the extent he determines such payments necessary to promote prompt initiation and advancement of the approved project.

§ 51c.109 Nondiscrimination.

(a) Attention is called to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252, (42 U.S.C. 2000d et seq.)) and in particular section 601 of such Act which provides that no person in the United States shall on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. A regulation implementing such title VI, which applies to grants made under this part, has been issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 CFR Part 80). In addition, no person shall, on the grounds of age, sex, creed, or marital status (unless otherwise medically indicated), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity so receiving Federal financial assistance.

(b) Attention is called to the requirements of section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

§ 51c.110 Confidentiality.

All information as to personal facts and circumstances obtained by the project staff about recipients of services shall be held confidential, and shall not be divulged without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary or his designee with appropriate safeguards for confidentiality of patient records. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.

§ 51c.111 Publications and copyright.

Except as may otherwise be provided under the terms and conditions of the award, the grantee may copyright without prior approval any publications, films, or similar materials developed or resulting from a project supported by a grant under this part, subject, however, to a royalty-free, nonexclusive, and irrevocable license or right in the Government to reproduce, translate, publish, use, disseminate, and dispose of such materials and to authorize others to do so.

§ 51c.112 Grantee accountability.

(a) *Accounting for grant award payments.* All payments made by the Secretary shall be recorded by the grantee in accounting records separate from the records of all other funds, including funds derived from other grant awards. With respect to each approved project, the grantee shall account for the sum total of all amounts paid as well as other funds and in-kind contributions by presenting or otherwise making available evidence satisfactory to the Secretary of expenditure for direct and indirect costs meeting the requirements of this part: *Provided, however,* That when the amount awarded for indirect costs was based on a predetermined fixed-percentage of estimated direct costs, the amount allowed for indirect costs shall be computed on the basis of such predetermined fixed-percentage rates applied to the total, or a selected element thereof, of the reimbursable direct costs incurred.

(b) *Accounting for interest earned on grant funds.* Pursuant to section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213), a State will not be held accountable for interest earned on grant funds, pending their disbursement for grant purposes. A State, as defined in section 102 of the Intergovernmental Cooperation Act, means any one of the several States, the District of Columbia, Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State, but does not include the government of the political subdivisions of the State. All grantees other than a State, as defined, must return all interest earned on grant funds to the Federal Government.

(c) *Grant closeout.* (1) *Date of final accounting.* A grantee shall render, with respect to each approved project, a full account, as provided herein, as of the date of the termination of grant support. The Secretary may require other special and periodic accounting.

(2) *Final settlement.* There shall be payable to the Federal Government as final settlement with respect to each approved project the total sum of:

(i) Any amount not accounted for pursuant to paragraph (a) of this section;

(ii) Any credits for earned interest pursuant to paragraph (b) of this section;

(iii) Any other amounts due pursuant to Subparts F, M, and O of 45 CFR Part 74.

§ 51c.113 Applicability of 45 CFR Part 74.

The provisions of 45 CFR Part 74, establishing uniform administrative requirements and cost principles, shall apply to all grants under this part to State and local governments as those terms are defined in Subpart A of that Part 74. The relevant provisions of the following subparts of Part 74 shall also apply to grants to all other grantee organizations under this part:

45 CFR PART 74

SUBPART

A General
B Cash depositories.
C Bonding and insurance.
D Retention and custodial requirements for records.
F Grant-related income.
G Matching and cost sharing.
K Grant payment requirements.
L Budget revision procedures.
M Grant closeout, suspensions, and termination.
O Property.
Q Cost principles.

Subpart B—Grants for Planning and Developing Community Health Centers

§ 51c.201 Applicability.

The regulations of this subpart, in addition to the regulations of subpart A of this subpart, are applicable to grants awarded pursuant to section 330(c) of the Act for projects for planning and developing community health centers which will serve medically underserved populations.

§ 51c.202 Application.

To be approved by the Secretary under this subpart, an application for a grant must, in addition to meeting the requirements of § 51c.104 of Subpart A, contain information sufficient to enable the Secretary to determine that the project for which the grant is sought will meet the requirements of § 51c.203.

§ 51c.203 Project elements.

A project for the planning and developing of a community health center supported under this subpart must:

(a) Prepare an assessment of the need of the population proposed to be served by the community health center for the services set forth in § 51c.102(c) (1) of Subpart A, with special attention to the need of the medically underserved population for such services. Such assessment of need shall, at a minimum, consider the factors listed in § 51c.102(c) (1)–(4).

(b) Design a community health center program for such population, based on such assessment, which indicates in detail how the proposed community health center will fulfill the needs identified in the assessment prepared pursuant to paragraph (a) of this section and how it will meet the requirements contained in subpart C of this part.

(c) Develop a plan for the implementation of the program designed pursuant to paragraph (b) of this section. Such implementation plan shall provide for the time-phased recruitment and training of the personnel essential for the operation of a community health center and the gradual assumption of operational status of the project so that the project will, in the judgment of the Secretary, meet the requirements contained in subpart C of this part as of the end of the project period.

(d) Implement the plan developed pursuant to paragraph (c) of this section in accordance with such paragraph.

(e) Make efforts to secure, within the proposed catchment area of such center to the extent possible, financial and professional assistance and support for the project.

(f) Initiate and encourage continuing community involvement in the development and operation of the project.

(g) Establish standards and qualifications for personnel (including the project director).

(h) Utilize, to the maximum extent feasible, other Federal, State, local, and private resources available for support of the project, prior to use of project funds under this subpart.

§ 51c.204 Grant evaluation and award.

(a) Within the limits of funds determined by the Secretary to be available for such purpose, the Secretary may award grants under this subpart to applicants therefor which will, in his judgment, best promote the purposes of section 330(c) of the Act and the applicable regulations of this part, taking into account:

(1) The degree to which the proposed project satisfactorily provides for the elements set forth in § 51c.203;

(2) The relative need of the population to be served for the services to be provided;

(3) The administrative and management capability of the applicant;

(4) The potential of the project for development of new and effective methods for health services delivery and management;

(5) The soundness of the fiscal plan for assuring effective utilization of grant funds and maximizing non-grant revenue;

(6) The extent to which community resources will be utilized in the project;

(7) The extent to which grants approved under this part will provide for an appropriate distribution of resources throughout the country, taking into consideration the following factors;

(i) The urban-rural area to be served;

(ii) The nature of the organization applying; and

(iii) The organizational structure for delivery of services;

(8) Whether the project's catchment area is exclusive of the area served by a community health center;

(9) The degree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health services or reimbursement programs or projects.

(b) The Secretary may:

(1) Make no more than two grants under this subpart for the same project.

(2) Make a grant under this subpart to an entity which has been awarded one or more grants under section 330(d)(1)(A) and/or section 330(d)(1)(B) of the Act only if the grant under this subpart is for a new project.

Subpart C—Grants for Operating Community Health Centers

§ 51c.301 Applicability.

The regulations of this subpart, in addition to the regulations of Subpart A, are applicable to grants awarded pursuant to section 330(d)(1)(A) of the Act for the costs of operation of community health centers which serve medically underserved populations.

§ 51c.302 Application.

To be approved by the Secretary under this subpart, an application for a grant must, in addition to meeting the requirements of § 51c.104 of Subpart A,

(a) Be submitted by an entity which the Secretary determines is a community health center, and

(b) Contain information sufficient to enable the Secretary to determine that the center will meet the requirements of § 51c.103.

§ 51c.303 Project elements.

A community health center supported under this subpart must:

(a) Provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner which will assure continuity of service to the residents of the center's catchment area.

(b) Implement a system for maintaining the confidentiality of patient records in accordance with the requirements of § 51c.110 of Subpart A.

(c) Have an ongoing quality assurance program which provides for the following:

(1) Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care;

(2) Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Such assessments shall:

(i) Be conducted by physicians or by other licensed health professionals under the supervision of physicians;

(ii) Be based on the systematic collection and evaluation of patient records; and

(iii) Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.

(d) Develop management and control systems which are in accordance with sound financial management procedures, including the provision for an audit on an annual basis (unless waived for cause by the Secretary) by an independent certified public accountant, or a public accountant licensed prior to December 31, 1970, to determine, at a minimum, the fiscal integrity of grant financial transactions and reports, and compliance with the regulations of this part and the terms and conditions of the grant.

(e) Where the cost of care and services furnished by or through the project is to be reimbursed under Title XIX or Title XX of the Social Security Act, obtain or make every reasonable effort to obtain a written agreement with the Title XIX or Title XX State agency for such reimbursement.

(f) Have prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts adjusted on the basis of the patient's ability to pay. *Provided*, That such schedule of discounts shall provide for a full discount to individuals and families with annual incomes at or below those set forth in the most recent CSA Poverty Income Guidelines (45 CFR 1060.2) and for no discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines, except that nominal fees for services may be collected from individuals with annual incomes at or below such levels where imposition of such fees is consistent with project goals.

(g) Make every reasonable effort, including the establishment of systems for eligibility determination, billing, and collection, to:

(1) Collect reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under Title XVIII of the Social Security Act, to medical assistance under a State plan approved under Title XIX of such Act, to social services and family planning under Title XX of such Act, or to assistance for medical expenses under any other public assistance program, grant program, or private health insurance or benefit program on the basis of the schedule of fees prepared pursuant to paragraph (f) of this section without application of any discounts, and

(2) Secure from patients payments for services in accordance with the schedule of fees and discounts required by paragraph (f) of this section.

(h) Have a governing board which mets the requirements of § 51c.304.

(i) Have developed an overall plan and budget for the center that:

(1) Provides for an annual operating budget and a three-year financial management plan which include all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items;

(2) Provides for a capital expenditures plan for at least a three-year period (including the year to which the operating budget described in paragraph (i)(1) of this section is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objective of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment and the replacement, modernization and expansion of buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) Provides for plan review and updating at least annually; and

(4) Is prepared under the direction of the governing board, by a committee consisting of representatives of the governing board, and administrative staff, and the medical staff, if any, of the center.

(j) Establish basic statistical data, cost accounting, management information, and reporting or monitoring systems which shall enable the center to provide such statistics and other information as the Secretary may reasonably require relating to the center's costs of operation, patterns of utilization of services, and the availability, accessibility, and acceptability of its services and to make such reports to the Secretary in a timely manner with such frequency as the Secretary may reasonably require.

(k) Review its catchment area annually to insure that the criteria set out in § 51c.104(b)(2) of Subpart A are met and, where such criteria are not met, revise its catchment area, with the approval of the Secretary, to conform to such criteria to the extent feasible.

(l) In the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, have developed a plan and made arrangements responsive to the needs of such populations for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and have identified an individual on its staff who is fluent in both that language and in English and whose responsibilities include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences. If more than one non-English language is spoken by such group or groups, an individual or individuals fluent in those languages and English shall be so identified.

(m) Be operated in a manner calculated to preserve human dignity and to maximize acceptability and effective utilization of services.

(n) To the extent possible, coordinate and integrate project activities with the activities of other Federally funded, as well as State and local, health services delivery projects and programs serving the same population.

(o) Establish means for evaluating progress toward the achievement of the specific objectives of the project.

(p) Provide sufficient staff, qualified by training and experience, to carry out the activities of the center.

(q) Assure that facilities utilized in the performance of the project meet applicable fire and life safety codes.

(r) Utilize, to the maximum extent feasible, other Federal, State, and local, and private resources available for support of the project, prior to use of project funds under this part.

(s) Provide for community participation through, for example, contributions of cash or services, loans of full- or part-time staff, equipment, space, materials, or facilities.

(t) Where the center will provide services through contract or other cooperative arrangements with other providers of services, establish rates and methods of payment for health care. Such payments must be made pursuant to agreements, with a schedule of rates and payment procedures maintained by the project. The project must be prepared to substantiate that such rates are reasonable and necessary.

(u) Operate in a manner such that no person shall be denied service by reason of his inability to pay therefor. *Provided, however,* That a charge for the provision of services will be made to the extent that a third party (including a Government agency) is authorized or is under legal obligation to pay such charges.

(v) In addition to the above, projects which are supported with grant funds for the operation of a prepaid health care plan also must provide:

(1) A marketing and enrollment plan, including market analysis, marketing strategy, and enrollment growth projections.

(2) A plan that provides for funding on a capitation basis of such portion of the residents of the catchment area of the center, as the Secretary shall determine.

(3) An assurance that services shall be available to all residents of the catchment area without regard to method of payment or health status.

§ 51c.304 Governing board.

A governing board for the center shall be established by an applicant as follows:

(a) *Size.* The board shall consist of at least 9 but not more than 25 members, except that this requirement may be waived by the Secretary for good cause shown.

(b) *Composition.* (1) A majority of the board members shall be individuals who are or will be served by the center and who, as a group, represent the individuals being or to be served in terms of demographic factors, such as race, ethnicity, sex.

(2) No more than one-half of the remaining members of the board may be individuals who derive more than 10 percent of their annual income from the health care industry.

(3) The remaining members of the board shall be representative of the community in which the center's catchment area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.

(4) No member of the board shall be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee. The project director may be a non-voting, ex-officio member of the board.

(c) *Selection of members.* The method of selection of all governing board members shall be prescribed in the by-laws or other internal governing rules of the center. Such by-laws or other rules must specify a process of selection of individuals on the governing board who represent the population served or to be served by the center so that such individuals, as a group, are representative of such population. Such process of selection in the by-laws or other rules is subject to approval by the Secretary.

(d) *Functions and responsibilities.* (1) The governing board for the center shall have authority for the establishment of policy in the conduct of the center.

(2) The governing board shall hold regularly scheduled meetings, at least once each month, for which minutes shall be kept.

(3) The governing board shall have specific responsibility for:

(i) Approval for the selection and dismissal of a project director or chief executive officer of the center;

(ii) Establishing personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices;

(iii) Adopting policy for financial management practices, including a system to assure accountability for center resources, approval of the annual project budget, center priorities, eligibility for services including criteria for partial payment schedules, and long-range financial planning;

(iv) Evaluating center activities including services utilization patterns, productivity of the center, patient satisfaction, achievement of project objectives, and development of a process for hearing and resolving patient grievances;

(v) Assuring that the center is operated in compliance with applicable Federal, State, and local laws and regulations; and

(vi) Adopting health care policies including scope and availability of services, location and hours of services, and quality-of-care audit procedures.

§ 51c.305 Grant evaluation and award.

Within the limits of funds determined by the Secretary to be available for such purpose, the Secretary may award grants under this subpart to applicants therefor which will, in his judgment, best promote the purposes of section 330(d)(1)(A) of the Act and the applicable regulations of this part, taking into consideration:

(a) The extent to which the project would provide for the elements set forth in § 51c.303;

(b) The relative need of the population to be served for the services to be provided;

(c) The potential of the center for the development of new and effective methods for health services delivery and management;

(d) The soundness of the fiscal plan for assuring effective utilization of grant funds and maximizing non-grant revenue;

(e) The administrative and management capability of the applicant;

(f) The extent to which grants approved under this part will provide for an appropriate distribution of resources throughout the country, taking into consideration the following factors:

(1) The urban-rural area to be served;

(2) The nature of the organization applying;

(3) The organizational structure for delivery of services;

(g) The number of users of the center and the level of utilization of services in previous operational periods, if any;

(h) Whether the center's catchment area is exclusive of the area served by another center;

(i) The degree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health services or reimbursement programs or projects;

(j) The extent to which community resources will be utilized by the project;

(k) The extent to which the center will provide preventive health services so as to maintain and improve the health status of the population served; and

(l) The extent to which center operations will emphasize direct health services, efficiency of operations and sound financial management.

Subpart D—Grants for Operating Community Health Projects

§ 51c.401 Applicability.

The regulations of this subpart, in addition to the regulations of Subpart A are applicable to grants awarded pursuant to section 330(d)(1)(B) of the Act for the costs of operation of projects which provide health services to medically underserved populations.

§ 51c.402 Application.

To be approved by the Secretary under this subpart, an application for a grant must, in addition to meeting the requirements of § 51c.104 of Subpart A, contain information sufficient to enable the Secretary to determine that the project for which the grant is sought will meet the requirements of § 51c.403 of this subpart.

§ 51c.403 Project elements.

A project for the operation of a community health project supported under this subpart must:

(a) Meet all of the requirements of § 51c.303 of this part except for paragraph (h).

(b) Provide those services enumerated in § 51c.102(c) (1) of this part which the Secretary determines to be feasible and desirable and which are specified in the grant award.

(c) Establish a governing board meeting the requirements of § 51c.304 by the end of the period of support under section 330(d) (1) (B) of the Act and this subpart.

§ 51c.404 Grant evaluation and award.

(a) Within the limits of funds determined by the Secretary to be available for such purpose, the Secretary may award grants under this subpart to applicants therefor which will, in his judgment, best promote the purposes of section 330(d) (1) (B) of the Act and the applicable regulations of this part,

(1) Where the project meets the requirements of § 51c.403(a); and

(2) Taking into consideration the following:

(i) The degree to which the project would provide the services enumerated in § 51c.102(c) (1) and the feasibility of its providing all of such enumerated services by the end of the period of support under section 330(d) (1) (B) of the Act and this subpart;

(ii) Whether the project will have a governing board meeting the requirements of § 51c.304 by the end of the period of support under section 330(d) (1) (B) of the Act and this subpart;

(iii) The degree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health service or reimbursement programs or projects;

(iv) The need of the population to be served for the services to be provided;

(v) The potential of the project for the development of new and effective methods for health services delivery and management;

(vi) The soundness of the fiscal plan for assuring effective utilization of grant funds and maximizing non-grant revenue;

(vii) The administrative and management capacity of the applicant; and

(viii) The extent to which community resources will be utilized in the project.

(b) The Secretary may:

(1) Make no more than two grants for the same entity under section 330(d) (1) (B) of the Act;

(2) Not make any grant under section 330(d) (1) (B) to an entity which, for the same project, has been awarded more than one grant under section 330(c) of the Act;

(3) Not make a grant under section 330(d) (1) (B) to an entity which has been awarded a grant under section 330 (d) (1) (A) of the Act.

[FR Doc.76-35277 Filed 12-2-76;8:45 am]

Testimony Before the U.S. Civil
Rights Commission Hearings
Denver, Colorado
July 28, 1977

By: Armando R. Atencio
Deputy Manager for Operations
and Finance
Department of Health & Hospitals

The Denver Department of Health and Hospitals is a public Agency under the Mayor of the City and County of Denver. The Manager of the Department is a Charter Officer and a member of the Mayor's Cabinet.

The responsibilities of the Department of Health and Hospitals as spelled out in the Charter, are as follows. The Department shall administer and exercise all health programs and functions of the City and County of Denver, including the following specifically enumerated functions:

1. The physical and mental health of the people.
2. Investigation and control of communicable diseases.
3. Operation of Municipally owned institutions, maintained for the care of the sick, aged, injured, or mentally ill.

In order to carry out its Charter responsibilities, the Department of Health and Hospitals has developed a broad, comprehensive, and totally integrated Health Care Delivery system, designed to take care of the physical and mental health care needs of people from birth through old age.

The components of this system are as follows:

Denver General Hospital
Emergency Services
Neighborhood Health Centers
Neighborhood Health Stations
Mental Health Center Facilities
Drug Abuse Clinics
Alcoholism Program
Detention Ward
Department of Public Health
Visiting Nurse Services

The integrated nature of this system makes it possible for people to receive care on a preventative ambulatory basis, receive specialized care in a variety of specialists, and In-Patient services in a modern 342 bed General Hospital.

Funding for this health care system comes from City appropriations, State Grants and Contracts, and Federal Grants and Contracts. Total funding by source and percentage for 1977 is as follows:

Source	Amount	Percentage
City Funds	$ 19,104,000	35%
State Funds - Grants and Contracts	$ 3,558,000	6%
Federal Funds - Grants and Contracts	$ 6,882,000	13%
Reimbursements	$ 24,500,000	45%
Other Hospital Income	$ 413,000	1%

The population of the City and County of Denver is approximately 514,678. Total population and users of services in the Denver Health and Hospital Health system is divided by sex and age, as follows:

Females	Denver Pop.	%	H & H Users	%
Ages up to 17	77,206	15.0	9,187	18.4
18 - 20	16,353	3.2	2,623	5.3
21 - 34	57,677	11.2	9,132	18.3
35 - 44	27,187	5.3	2,200	4.4
45 - 64	56,880	11.1	3,580	7.2
65 - Over	35,786	7.0	1,771	3.6
Sub. Total	271,089	52.7	28,493	57.1

Males	Denver Pop.	%	H & H Users	%
Ages up to 17	79,302	15.4	8,409	16.9
18 - 20	13,916	2.7	1,066	2.1
21 - 34	52,991	10.3	5,842	11.7
35 - 44	25,455	4.9	1,849	3.7
45 - 64	48,925	9.5	2,929	5.9
65 - Over	23,000	4.5	1,277	2.6
Sub. Total	243,589	47.3	21,372	42.9
Total	514,678	100	49,865	100

The above data indicates that young people up to 17 years of age use our Health Care Delivery System at a proportionately higher rate than their representative number in the general population. The reason for this is probably because of our emphasis on preventative care, including well baby clinics.

As you move towards the older groups, the percentage of users in both males and females tend to decrease proportionately to their number

in the general population. This is understandable, since middle aged people are more likely to be fully employed and therefore have the ability to afford health care from the private sector.

Of particular concern to us, has been the age group of 65 and over. It's our feeling that this age group uses our services to a lesser degree than other groups partially because the care of elderly patients requires special skills, attitudes and approaches, which are generally not a part of the general system of acute health care aimed largely at younger patients.

It also must be recognized that the elderly population to a large extent, while being economically indigent, may not necessarily be medically indigent because of their coverage under Title 18 of the Social Security Act. Therefore, it's possible that a higher percentage of people in this age group may be using the private sector for their health care.

Empirical data on this subject is unavailable for our system. We are therefore merely congesturing as to the reasons for the lower percentage of users in this age group.

In conclusion, it's our opinion that while our system is a broad comprehensive health care delivery system designed to provide services to all the residents of the City and County of Denver who are in need of publicly sponsored health care, there are groups of people in the Denver

population who use our system to a lesser extent than might be expected. Whether this can be viewed as a form of discrimination because of age, is a difficult fact to ascertain. We can unequivocally state that our Department does not in any way attempt to design the services for the purpose of excluding any one or any group because of age, sex, race, ethnic origin, religious beliefs, or political affiliation.

Exhibit No. 5

UNITED STATES GOVERNMENT DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE

Memorandum

TO : Dr. Stanley Mahoney DATE: July 20, 1977

FROM : Mr. John A. Nelson REFER TO:

SUBJECT: Selected Population Groupings for Region VIII[1]

TOTALS FOR REGION VIII:

Total Population:	6,180,000	
15 and under:[2]	1,782,000	28.8% of Region VIII
65 and over:	810,000	13.1% of Region VIII

STATE TOTALS:

Colorado: [2,534,000]

15 and under:	697,500	27.5% of state
65 and over:	210,000	8.3% of state

Montana: [748,000]

15 and under:	211,500	28.2% of state
65 and over:	75,000	10.0% of state

North Dakota: [635,000]

15 and under:	178,000	28.0% of state
65 and over:	73,000	11.5% of state

South Dakota: [683,000]

15 and under:	191,000	27.9% of state
65 and over:	85,000	12.5% of state

Utah: [1,206,000]

15 and under:	398,500	33.0% of state
65 and over:	91,000	7.5% of state

Wyoming: [374,000]

15 and under:	105,500	28.2% of state
65 and over:	33,000	9.0% of state

[1] SOURCE: U.S. Bureau of the Census, Statistical Abstract of the United States: 1976, Washington, D. C.

[2] All 15 and under figures have been prorated.

UNITED STATES GOVERNMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE

Memorandum

TO : Dr. Stanley Mahoney

DATE: July 20, 1977

FROM : Mr. John A. Nelson

REFER TO:

SUBJECT: Report for Age Discrimination Study
Re: Persons Sixty-five and Over

The following chart provides an analysis of information drawn from the Community Mental Health Centers Profile Data. Specifically, the data pertains to the utilization of Federally funded community mental health centers (CMHC) by persons who are 65 years of age and above. This analysis was done to acquire a clearer understanding of the impact of these programs on the 65+ population.

The chart does not represent a total sample of the Federally funded CMHC's in Region VIII. Rather, this survey draws on a 60% sample.

The findings in the following chart are not presented as being infallible for there are several obvious limitations to the data. First, it is secondary data which was derived from a previous collection of statistics. As such it is vulnerable to the innate problems of all secondary data. Second, false low scores may occur if the data measures only psychiatric examinations instead of the center's total involvement (i.e., consultation and education efforts) with the 65+ population. Third, it must be pointed out that low percentages of utilization should not be interpreted as clear evidence of center discrimination. Many social-cultural variables may provide an interaction effect which predisposes the 65+ not to seek traditional treatment settings. A survey of the total human service system within the catchment area may reveal a high level of impact on the 65+ population even though involvement with the CMHC may be low. There are advantages, however, that make the following analysis a useful tool in assessing the impact of the CMHC on the 65+ population.

With all its weaknesses the chart information and format is at least a starting point from which to refine the data collection system. The data used is the most accurate, documented information available concerning the 65+ population in Region VIII.

The following analysis draws to the fore the need to establish more uniform measures of CMHC utilization before any clear evidence of discrimination can be determined. Is utilization measured by psychiatric evaluations or by the CMHC's total involvement with the community?

In addition to using the percent of CMHC caseload which is 65+ as an indicator of utilization, the chart also contains the percent of the total catchment area population 65+ who are receiving CMHC service. This indicator is being introduced as a useful measure of utilization and impact. This method helps to minimize false high percentages of 65+ caseload counts due to low caseload number in relation to the catchment area population.

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS

BY PERSONS SIXTY-FIVE AND OVER IN REGION VIII*

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are 65+	% Of CA Which Is 65+	CMHC Caseload	% Of Caseload 65+	% Of 65+ In CA Served By CMHC
COLORADO:						
Adams County Mental Health Center	185,789	6,642	3.6	2,833	1.0	.0042
Arapahoe Mental Health Center, Inc.	174,452	9,460	5.4	1,411	0.6	.0008
Bethesda Community Mental Health Center	125,405	14,444	11.5	795	1.0	.0006
Mental Health Center of Boulder	131,889	9,145	6.9	2,365	0.5	.0014
Jefferson County Mental Health Center	239,122	12,735	5.3	2,317	0.8	.0014
Midwestern Colorado Mental Health Center	46,356	5,742	12.4	231	1.7	.0007
Northwest Denver Mental Health Center	180,744	26,461	14.6	7,440	2.2	.0061
San Luis Valley Comprehensive Mental Health Center	37,466	3,701	9.9	237	3.4	.0022
Weld Mental Health Center, Inc.	89,297	7,894	8.8	927	0.4	.0005

* SOURCE: Community Mental Health Center Profile Data; 1976

LEGEND: CA--catchment area
CMHC--community mental health center

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS
BY PERSONS SIXTY-FIVE AND OVER IN REGION VIII

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are 65+	% Of CA Which Is 65+	CMHC Caseload	% Of Caseload 65+	% Of 65+ In CA Served By CMHC
MONTANA:						
Eastern Montana Regional Mental Health Center	92,152	9,743	10.6	921	2.0	.0018
South Central Montana Regional Mental Health Center	144,862	14,916	10.3	1,382	1.4	.0013
Western Montana Regional Community Mental Health Center	154,691	14,914	9.6	1,630	1.4	.0015
NORTH DAKOTA:						
Center for Human Development	93,857	9,583	10.2	465	1.5	.0007
Memorial Mental Health and Retardation Center	104,207	9,615	9.2	696	1.3	.0009
North Central Mental Health and Retardation Center	100,360	9,245	9.2	806	3.7	.0032
South Central Mental Health and Retardation Center	78,965	10,650	13.5	777	7.6	.0056
UTAH:						
Four Corners Mental Health Center	37,078	3,018	8.1	658	3.8	.0083
Granite Community Mental Health Center	193,207	7,706	4.0	3,645	0.006	.0029

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS
BY PERSONS SIXTY-FIVE AND OVER IN REGION VIII

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are 65+	% Of CA Which Is 65+	CMHC Caseload	% Of Caseload 65+	% Of 65+ In CA Served By CMHC
Salt Lake Community Mental Health Center	175,944	23,385	13.3	2,728	2.6	.0030
Timpanogos Community Mental Health Center	154,092	9,748	6.3	891	4.2	.0038
Weber County Mental Health Center	130,261	10,069	7.7	1,116	1.4	.0016
WYOMING:						
Northern Wyoming Mental Health Center	47,238	5,159	10.9	1,645	2.1	.0068
Southeast Wyoming Mental Health Center	100,162	8,668	8.7	1,389	1.4	.0064

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS

BY PERSONS FIFTEEN AND UNDER IN REGION VIII*

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are <15	% Of CA Which Is <15	CMHC Caseload	% Of Caseload <15	% Of <15 In CA Served By CMHC
COLORADO:						
Adams County Mental Health Center	185,789	67,568	36.4	2,833	16.1	.0067
Arapahoe Mental Health Center, Inc.	174,452	55,827	32.0	1,411	23.8	.0060
Bethesda Community Mental Health Center	125,405	28,987	23.1	795	3.3	.0009
Mental Health Center of Boulder	131,889	36,885	28.0	2,365	12.4	.0079
Jefferson County Mental Health Center	239,122	77,110	32.2	2,317	18.1	.0005
Midwestern Colorado Mental Health Center	46,356	13,024	28.1	231	6.5	.0012
Northwest Denver Mental Health Center	180,744	42,722	23.6	7,440	9.8	.0171
San Luis Valley Comprehensive Mental Health Center	37,466	12,019	32.1	237	11.4	.0022
Weld Mental Health Center, Inc.	89,297	25,600	28.7	927	11.1	.0040

* SOURCE: Community Mental Health Center Profile Data; 1976

LEGEND: CA--catchment area
CMHC--community mental health center

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS

BY PERSONS FIFTEEN AND UNDER IN REGION VIII

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are <15	% Of CA Which Is <15	CMHC Caseload	% Of Caseload <15	% Of <15 In CA Served By CMHC
MONTANA:						
Eastern Montana Regional Mental Health Center	92,152	29,074	31.6	921	38.7	.0126
South Central Montana Regional Mental Health Center	144,862	42,295	29.2	1,382	21.7	.0071
Western Montana Regional Community Mental Health Center	154,691	46,393	30.0	1,630	12.3	.0043
NORTH DAKOTA:						
Center for Human Development	93,857	27,012	28.8	465	8.8	.0015
Memorial Mental Health and Retardation Center	104,207	33,812	32.4	696	32.3	.0022
North Central Mental Health and Retardation Center	100,360	31,045	30.9	806	13.2	.0034
South Central Mental Health and Retardation Center	78,965	22,358	28.3	777	13.1	.0046
UTAH:						
Four Corners Mental Health Center	37,078	12,643	34.1	658	17.8	.0093
Granite Community Mental Health Center	193,207	73,175	37.9	3,645	11.4	.0056

UTILIZATION OF FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS
BY PERSONS FIFTEEN AND UNDER IN REGION VIII

Community Mental Health Center	Total CA Pop.	CA Pop. Who Are <15	% Of CA Which Is <15	CMHC Caseload	% Of Caseload <15	% Of <15 In CA served By CMHC
Salt Lake Community Mental Health Center	175,944	43,083	24.5	2,728	14.2	.0090
Timpanogos Community Mental Health Center	154,092	48,326	31.4	891	11.0	.0020
Weber County Mental Health Center	130,261	41,955	32.2	1,116	10.1	.0026
WYOMING:						
Northern Wyoming Mental Health Center	47,238	13,889	29.4	1,645	16.2	.0192
Southeast Wyoming Mental Health Center	100,162	28,280	28.2	1,389	13.1	.0064

Percentage of children, adolescents, and geriatrics on Park East active client load December, 1974 through September 1976.

	Age 0-17	Age 65+
December, 1974	3.0%	2.5%
March, 1975	7.0%	2.2%
June, 1975	10.3%	1.8%
December, 1975	12.4%	1.2%
June, 1976	11.0%	1.2%
September, 1976	10.1%	1.2%

Figure 2

TOTAL POPULATION OF NORTHWEST CATCHMENT

DENVER, COLORADO

TOTAL POP 180744 MALES (85338) FEMALES (95406)

NUMBER	%	AGE	9	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	9	%	NUMBER
764	0.4	85+									M	F	F	F	F						0.8	1476
1268	0.7	80-4									M	F	F	F	F						1.2	2190
2019	1.1	75-9									M	F	F	F	F						1.9	3371
2816	1.6	70-4									M	F	F	F	F						2.4	4275
3548	2.0	65-9									M	F	F	F	F						2.6	4734
4197	2.3	60-4									M	F	F	F	F						2.9	5251
4369	2.4	55-9									M	F	F	F	F						2.9	5252
4262	2.4	50-4									M	F	F	F	F						2.8	4994
4185	2.3	45-9									M	F	F	F	F						2.6	4669
3950	2.2	40-4									M	F	F	F	F						2.3	4166
3732	2.1	35-9									M	F	F	F	F						2.0	3595
4545	2.5	30-4									M	F	F	F	F						2.2	4042
7417	4.1	25-9								M	M	F	F	F	F						3.7	6758
9261	5.1	20-4							M	M	M	F	F	F	F						6.3	11348
7405	4.1	15-9								M	M	F	F	F	F						4.5	8163
6763	3.7	10-4								M	M	F	F	F	F						3.7	6706
7107	3.9	5-9								M	M	F	F	F	F						3.9	7092
7730	4.3	0-4								M	M	F	F	F	F						4.0	7324

1970 Census Data
Prepared by Research and Evaluation November, 1974

TRAINING CONTRACT - Nursing Home April thru June, 1977

University of Denver
School of Professional Psychology

Amount: $4,000.00, payable in three stages

Terms: A training project to involve families of nursing home patients in helping them meet patient mental health needs.

Working through the Southwest Denver Mental Health Center, access was provided to two nursing homes in its catchment area, who agreed to work with the project team. Through staff of these two homes, patients suitable for this project were selected. In some cases where blood relatives could not be involved, it was possible to involve close friends who fit the "social network" style of approach.

According to the second report from the project training coordinator, this project is reflecting a satisfying degree of success, manifested in the fact that one of the patients has left the nursing home and another is in the process of leaving.

While stage 3 will include a full report and evaluation of this project, implications for future benefits of this contract are very good. The insights developed and material generated for use by faculty of the School of Psychology will undoubtedly carry over to students at the school. The possibility of continuing this type of training in the future through a training grant or similar approach could also result.

Report covering final stage of this contract is due and expected at any time.

Prepared by Grace Patston, ADAMH, Region VIII staff.

Submitted by Stanley C. Mahoney, Ph.D., Director, ADAMHA Division, PHS Region VIII. Testimony submitted at public hearing conducted by the U. S. Commission on Civil Rights, Age Discrimination Study, Denver, CO July 28, 1977

TECHNICAL ASSISTANCE PROJECT

(Cooperative Venture Between the Alcohol, Drug Abuse and Mental Health Division, PHS, Region VIII, and the Center for the Study of the Mental Health of the Aged, NIMH)

July 28, 1977

A technical assistance project, delivering technical assistance to six participating Comprehensive Community Mental Health Centers, is in progress in Region VIII at the present time. The project, based on a proposal by the Center for the Study of the Mental Health of the Aged, NIMH, is expected to culminate in recommendations that may be used by centers staff to develop a range of services for the mentally impaired elderly in the center catchment areas. This technical assistance is being rendered by three teams of two consultants each, working with center staff, and is being accomplished in two stages:

Stage 1. Includes study of pertinent information concerning centers selected prior to working with the staff of the centers.

Spending three days working directly with administrative and program staff of the centers.

A fourth day offers a program planning seminar, inviting State staff, other community mental health center directors and staff, and others concerned with the delivery of mental health services to the impaired elderly.

At this time, Stage 1 has been completed at two centers, two are in progress at the time of this writing and the remaining two centers will be visited in August.

Reports are to be submitted within 30 days after completion of Stage 1 and should include: the current status of the center's programs for the elderly; description of program development plans agreed upon by the center, including goals and objectives; steps to be taken by the center to implement agreed upon plans; and a time-table for implementation.

Stage 2. Will involve follow-up site visits to the centers six months after the initial visit to assess progress and render any further technical assistance the centers may require.

Final reports will be submitted within 30 days after follow-up and will include: evaluation of progress made by centers in implementing programs; the center's adherence to the timetable

for program implementation; any difficulty centers are experiencing in implementing the program; and estimation of the need of the center for further technical assistance.

Consultants for this technical assistance project were selected on the basis of strengths and expertise in the area of gerontology as well as program planning and development.

Prepared by Grace Patston, ADAMH, Region VIII staff.

Submitted by Stanley C. Mahoney, Ph.D., Director, ADAMHA Division, PHS Region VIII. Testimony submitted at public hearing conducted by the U. S. Commission on Civil Rights, Age Discrimination Study, Denver, CO July 28, 1977

THE COLORADO
MENTAL HEALTH PLAN
(1976 - 1981)

A plan based on use of the least restrictive alternative in the treatment of the mentally disabled.

August 1976

PREPARED BY

COLORADO DIVISION OF MENTAL HEALTH

James R. Dolby, Ph.D.
Director

State Plan Committee Members:

Robert B. Abelson, Ph.D.	Division of Mental Health
Capen Farmer, Ph.D.	Arapahoe Mental Health Center
Sidney M. Glassman, Ph.D.	Division of Mental Health
Robert L. Hawkins, ACSW	Colorado State Hospital
Floyd H. Martinez, Ph.D.	Mental Health Center of Boulder County
Earl McCoy, ACSW	Fort Logan Mental Health Center
Youlon D. Savage, ACSW (Chairman)	Division of Mental Health
Frederick J. Wells, Ph.D.	Mental Health Association of Colorado

DI76 MH2 H5

FOREWORD

The prevention and treatment of mental illness is the *raison d'etre* for the Division of Mental Health, the state hospitals and the mental health centers and clinics which comprise the public mental health services system. The basic philosophy and value system underlying this plan and the delivery of mental health services in Colorado can be summarized as follows: Persons in need of mental health services have the right to high quality services, provided close to home, without unreasonable delay. Services should be provided in the least restrictive setting, in a manner which preserves privacy and human dignity and interferes to the least extent possible with the individual's freedom. The primary objectives should be to prevent or relieve emotional suffering and to facilitate the best and most productive functioning of which the individual is capable.

THE COLORADO MENTAL HEALTH PLAN

I N D E X

APPENDICES

- 1.1 -

THE COLORADO MENTAL HEALTH PLAN

I. INTRODUCTION

A. PURPOSE

The Colorado Mental Health Plan was developed to provide direction for the planning and delivery of public mental health services during the next five years. More specifically, the purposes of the Plan are to assist in providing: systematic determination of mental health service needs, and the additional planning necessary to address these needs; the delivery of quality care by a well-organized, integrated system; and the delivery of cost-effective services.

The following requirements of a statewide mental health plan are incorporated in the purposes listed above: identify gaps in and duplication of services; determine mental health personnel needs; provide for citizen input; facilitate coordination with other agencies; develop standards to insure quality care; clarify the roles of the components of the system; provide a basis for funding; and develop goals with measurable objectives.

B. ORGANIZATION AND SCOPE

The six chapters and five appendices of the plan address the requirements of Public Law 94-63 (the Community Mental Health Center's Act of 1975), and state statutes. Following the introductory

chapter is one on the administration of the Plan. This chapter identifies the State Mental Health Authority and organizational structure, and provides for the appointment of a State Mental Health Advisory Council. The procedures for the annual review of the State Plan and the administration of Public Health Service Act funds (Section 314d) are detailed. The required federal assurances are included in this chapter, as are personnel standards relating to civil service, equal employment and affirmative action.

Chapter III is regarded as the "heart" of the Plan as it sets forth the goals and objectives which provide both specific direction and a means of assessing progress. The goals and objectives are developed around the principles detailed in Chapter I emphasizing the use of the least restrictive setting, protection of human dignity and the client's rights, the availability of services close to home, and accountability. The use of the least restricitve setting principle requires conscious effort to avoid inpatient hospitalization, when a less intensive form of treatment, such as outpatient care, will adequately meet the client's clinical needs. Implementation of this principle also requires the development of a range of locally available treatment facilities which can be used in lieu of inpatient care. Prevention and the special needs of target populations are also key foci of the goal statements and the accompanying objectives.

The state mental health program, as it is and as it will evolve in accordance with the Plan, constitutes the content of Chapter IV. The requirements for pre-admission screening emphasize the thrust towards avoiding inpatient hospitalization except in those instances where it

is clearly indicated. Those clients who require inpatient care in a state hospital will be assured of high quality services because of the intensive and extensive quality assurance and utilization review programs in effect in both hospitals.

Chapter IV also focuses on the discharge of clients from inpatient and other more intensive forms of care, and the procedures to insure appropriate follow-up. The intent is to insure that clients who require aftercare services receive such care in a pre-planned and systematic way, and that those who require living arrangements where treatment is available are properly placed.

Workforce issues including available resources, training programs and possible displacement are addressed. The possible displacement of state hospital employees because of the emphasis on deinstitutionalization and the use of alternatives to inpatient care is a key issue. The reasons this will probably have less harmful impact on state employees in Colorado are outlined. Coordination of mental health services with other human services planning and caregiving agencies is the almost overwhelming but essential task addressed in Chapter V. This chapter, and the goals and objectives speak to processes and mechanisms for constructive resolution of "boundary" problems toward the end of providing better care to more clients at the lowest possible cost.

Appropriate attention is given the complex health planning arena where, because there are many players, coordination is more difficult.

The interface between the Division of Mental Health and the Division of Alcohol and Drug Abuse is the focus of specific planning designed to increase cooperative planning which will result in better use of

available funds, additional funding, and consequently the availability of appropriate substance abuse services to more clients.

Chapter VI describes the present services and the mental health service needs of the communities served by the 24 mental health centers/clinics. The catchment area concept is supported to the extent it allows flexibility in the sharing and centralization of services where clinically feasible and economically desirable. The priorities for the funding of services and facilities in the various catchment areas will be determined, to a great extent, by the rankings of centers/clinics based on need. The rankings are indicated in Appendix III.

This chapter also deals with the development of community mental health resources and facilities for centers/clinics.

The appendices consist of a listing of the agencies and organizations from which input was sought and/or received, the Report of the Chicano Mental Health Planning Symposium, the rankings (based on need) of community mental health centers/clinics, the inventory of existing facilities, and the basis for the rankings of centers/clinics, the survey of need.

It is recognized that the implementation of this Plan is dependent, to a very large extent, upon funding. However, funding as such is not within the scope of this Plan. Specific sections of the Plan will be incorporated in annual budget requests, and the Plan itself will be a basic document available to legislators, and others with funding responsibilities, and used in budget presentations.

The Standards/Rules and Regulations required by Public Law 94-63 have been published in a separate document.

- 1.5 -

C. PHILOSOPHY

The philosophy of the Division of Mental Health is reflected throughout this Plan. This philosophy, expressed as principles, is categorized under the following four headings:

1. Human Dignity, Privacy and Client's Rights

   a. Mental health services should be provided in a manner which preserves the client's privacy and dignity.

   b. Clients have a right to know the type of treatment they will receive and the reasons for a particular type of treatment.

   c. Clients have the right to participate in setting their treatment goals.

   d. Clients have the right to receive services meeting customary standards of professional quality.

   e. Individuals have the right to refuse treatment unless they are found to be a danger to themselves or others, or are gravely disabled.

   f. Involuntary clients have the same right to goal-oriented treatment as do voluntary clients.

   g. Clients' rights should be vigorously protected. The services of an advocate should be available to involuntary clients.

   h. The written consent of the client shall be obtained before information concerning the client is released to others, except in those instances where release of information without the client's consent is specifically permitted by statute.

2. Least Restrictive Setting

Each client should be treated in the least intensive or restrictive setting consistent with the client's clinical needs (e.g., a client should not be hospitalized if a less intensive type of care will adequately meet his/her treatment needs).

3. Availability of Services Close to Home

   a. Mental health services should be provided in the local community, as close as possible to the home of the client.

   b. Entry into the public mental health system should be through the local mental health center or clinic. Every effort should be made to treat the client at this level on an outpatient basis before referring the client for more intensive care.

   c. The mental health system should provide consultative services to other agencies such as schools, social service departments, the clergy, etc., to help increase the capabilities of these agencies and individuals in the early detection of, and effective intervention in, emotional problems.

   d. Closely related to the principles of the availability of services close to home and in the least restrictive setting is the concept of normalization; i.e., services should be provided in the most normal or home-like setting possible.

4. Funding and Accountability

   a. The primary responsibility for public mental health care should rest with the state; however, it is recognized that part of the financial burden should be assumed by local governments, the federal government, employers and those who receive services.

b. Clients should be billed in accordance with their ability to pay.

c. Maximum effort should be made to obtain reimbursement for services to clients, who are eligible, for Medicare (Title XVIII), Medicaid (Title XIX) and other third party mental health benefits.

d. There should be a continuous effort to measure the impact or results of mental health services. Agencies and programs which provide effective services at low cost should receive special recognition, and their methodology should be studied for possible use by other agencies.

e. The results of ongoing evaluation of mental health services should be reflected in the planning process.

D. HOW THE PLAN WILL BE USED

This Plan will be widely distributed within and outside the mental health system. It will be used within the system as a statement of policy, to clarify the roles of the various components, to unify the various agencies around common goals, for program direction, to provide a rational basis for the allocation and utilization of funds, and to assess progress.

The plan will also be used as a vehicle for improving communication between the mental health system and other agencies and organizations, and as a documented and coherent basis for funding requests.

E. PROCESS BY WHICH THE PLAN WAS DEVELOPED

1. Planning Committee

   a. A planning committee was appointed by the Director, Division of Mental Health comprised of:

      (1) three members of the Division of Mental Health Central Office staff;

      (2) two representatives of the Colorado Association of Community Mental Health Centers and Clinics;

      (3) one representative of the Mental Health Association of Colorado; and

      (4) one representative from each of the two state hospitals.

   b. Notification of Intent (A-95 process) was initiated.

   c. The Committee reviewed a variety of approaches for preparation of a first draft. Their decision was to form a number of small task forces and to assign each the responsibility for writing a section or sections of the first draft of the Plan utilizing available input. The draft was reviewed by the Committee, the federal contact officer and others, and a second draft was prepared. The second draft was widely distributed and comments were elicited. The final draft incorporates many of the contributions of the various reviewers. (See Appendix I for a list of agencies and organizations from which input was requested and/or received.)

   d. The Plan was then submitted to the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Regional Office.

II. ADMINISTRATIVE INFORMATION

A. STATE MENTAL HEALTH AUTHORITY

The Department of Institutions is designated the official mental health and mental retardation authority and is authorized to receive grants-in-aid from the federal government under the provisions of 42 U.S.C. 246, and will administer such grants in accordance therewith (CRS 27-1-206, 1973).

The Executive Director of the State Department of Institutions is Raymond Leidig, M.D. The Executive Director is appointed by the Governor with the consent of the Senate and serves as a confidential employee of the Governor. The Department has five major Divisions: 1) Mental Health; 2) Developmental Disabilities; 3) Corrections; 4) Deaf and Blind; 5) Youth Services. (See Figure 1 for Organizational Chart of the Department of Institutions)

Address: Statutory Authority

Raymond Leidig, M.D., Executive Director
Department of Institutions
4150 South Lowell Boulevard
Denver, Colorado 80236

The Director of the Division of Mental Health is appointed by the Executive Director of the Department of Institutions. The Director of the Division of Mental Health is responsible for planning, organizing and directing the State's mental health program for the prevention and treatment of mental and emotional disorders. He has line supervision over Colorado State Hospital and Fort Logan Mental Health Center, and

the staff of the central office of the Division. He is responsible for the general effectiveness of the Division programs, activities and operations. (See Figure 2 for Organizational Chart of the Division of Mental Health)

Address: James R. Dolby, Ph.D., Director
Division of Mental Health
4150 South Lowell Boulevard
Denver, Colorado 80236

B. STATE MENTAL HEALTH ADVISORY COUNCIL

1. Membership

The State Mental Health Advisory Council will consist of 21 members who will be residents of Colorado. Only nine (9) members of the council will be direct or indirect providers of mental health services. The membership of the council should include representatives of those elements of the health service delivery system whose decisions impact the goals of: health care cost containment; access to health care services; appropriate placement; and continuity of care. Examples of sources for consumer and non-consumer members are:

a. Mental Health Association of Colorado;

b. Health systems agency boards of directors;

c. Health care payors (e.g., private insurance industry, medicaid administration);

d. League of Women Voters;

e. Child, Adolescent, and Senior Citizen Advocacy groups;

f. Ethnic Minority Advocacy groups;

g. Health manpower education and training institutions and agencies;

h. Allied health and social support providers (e.g., Nursing home industry, Community Care Organizations, etc.);

i. Health care and other human service licensure boards;

j. Former or present clients and/or family member;

k. Elected officials;

l. Board and/or staff member of mental health centers and clinics;

m. Voluntary human service agencies;

n. Private health care sector;

o. State departments and agencies;

p. School districts.

2. Selection Process

The Council shall be appointed by the Governor. For the first year of the council's existence, ten (10) members shall be appointed for one year terms and eleven (11) members for two year terms. From the second year forward, expired memberships shall be filled by the Governor for two year terms, except that appointments to fill unexpired terms of members who resign shall be for the unexpired terms of the resigned members. No council member shall serve more than five consecutive years.

Any citizen may nominate persons to serve on the council. The names of nominees may be submitted to the Governor, the Director, Division of Mental Health, or the Council.

The selection process will be implemented in such a manner as to ensure appropriate representation of the various geographic areas of the state, as well as the social, economic, and ethnic groups residing in the state.

3. Functions, Responsibilities and Procedures

The State Mental Health Advisory Council will function as an official advisory body to the Division of Mental Health concerning the development, revision, and administration of the State Plan. In that role, it functions as a collective voice for the mental health service client, provider, planner, administrator, and concerned citizen.

Among the Council's responsibilities are the following:

a. the Council will meet as often as necessary to review and critique development and implementation of the State Plan;

b. the Council will meet as often as necessary but not less than quarterly to consult with the State agency on the development and administration of the State Plan;

c. the Council will maintain a record of the dates of council meetings, issues considered, and a record of actions taken, including specific reference to the required annual review of the State Mental Health Plan for inclusion in the annual up-date of the Plan;

d. the Council will serve as a standing committee of the State Health Coordinating Council with the approval of that body;

e. the Council will establish ad hoc groups for special assignments deemed necessary by the Council or the Director of DMH;

f. the Council will develop by-laws and appropriate operating guidelines to ensure smooth and continuous operation.

Each year the members of the council will elect a Chairperson and Vice-Chairperson from the Council membership. A recording secretary may be designated by the Chairperson. A quorum will consist of 11 members present at any meeting. With a quorum present at any Council meeting, a majority vote will decide all questions.

Meetings of the Council will be open to the public.

C. ASSURANCES

1. Reports and Records

The Division of Mental Health will annually, report in writing to the Regional Office of ADAMHA its evaluation of each facility's compliance with the Standards/Rules and Regulations for community mental health centers and clinics and will keep such records and afford such access thereto as the Regional Office may find necessary to assure correctness, compliance, and verification of such reports.

The Division of Mental Health will retain on file for at least three years beyond participation in the program all documents and accounting records related to any expenditures. They will take such steps as necessary to ensure that centers/clinics retain, for at least three years after final payment of federal funds, all financial records and documents related to expenditures for projects funded wholly or in part with federal funds.

2. Conflict of Interest

No full-time officer or employee of the Division of Mental Health, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from any applicant directly or indirectly for payment for services provided in connection with the planning, design, construction, equipping or operation of any projects funded under the Community Mental Health Centers Act.

D. ANNUAL REVIEW

1. Procedure for Annual Review

a. In November of each year the Division of Mental Health (DMH) will notify all recipients of the Plan that the annual review is underway. Concerned and affected agencies will be invited to comment on the Plan and recommend changes and revisions.

b. The DMH staff will review the comments and recommendations with the Advisory Council.

c. The Advisory Council will be requested to study the areas of primary concern and to recommend appropriate changes and revisions in the Plan.

d. A draft of the proposed revisions will be prepared for review by the Council.

e. After the Council review, the revised draft will be made available for public review.

f. When input generated during the public review has been appropriately considered by DMH and the Council, a final document, including the Council's comments, will be prepared for submission to the ADAMHA Regional Office.

2. Procedure for Publicizing the Plan

a. At least 30 days prior to the submission of the Plan to the ADAMHA Regional Office, a notice will be published in at least three major newspapers that the State Mental Health Plan is being up-dated, and that the proposed additions and changes are available for examination and comment.

b. Appropriate DMH staff will be available to discuss the Plan. Copies of the proposed changes and revisions will be available.

c. Within four months after final approval of the Plan a summary will be prepared for general distribution. The summaries will be made available to the Mental Health Association, centers/clinics, hospitals, and other agencies and organizations for distribution to the public.

E. PERSONNEL ADMINISTRATION

1. Personnel Standards

The State of Colorado has a merit system implemented through the State Personnel Department and governed by the State Personnel Board.

Sections 13-15 of the State Constitution provides for the establishment of a merit system. Hiring procedures, classification, compensation,

fringe benefits, grievance procedures and disciplinary actions for employees of Colorado State Hospital, Fort Logan Mental Health Center and the Division of Mental Health central office are determined in accordance with merit system regulations.

2. Non-Discrimination

The Division of Mental Health (DMH) will continue to comply with the letter and spirit of Federal Executive Order Nos. 11246 and 11375, the Civil Rights Act of 1964, as amended, the Governor's Executive Order dated April 16, 1975, the Colorado Antidiscrimination Act of 1957, as amended, the Equal Rights Amendment of 1972, and Rules and Regulations adopted by the State Personnel Board, which became effective July 1, 1975. The DMH policy in brief is to provide equal employment opportunities to all persons on the basis of individual merit without regard to race, creed, color, sex, age, national origin, marital status, family relationship, political or religious affiliations, organization membership or other non-merit factors. Compliance with this policy will be required of any agency from which the DMH purchases services.

The State of Colorado recognizes that a policy of nondiscrimination in itself is insufficient when attempting to reverse traditional patterns of discrimination. It is, therefore, necessary to implement a plan of affirmative action in order to identify discriminatory practices and initiate programs designed to replace those practices with positive approaches to human and organizational development. Such a program requires support and commitment from all levels, specific goals and the monitoring and evaluation of progress in achieving affirmative action

goals. The Division of Mental Health requires such affirmative action plans in its "Standards/Rules and Regulations for Mental Health Centers and Clinics." The Division of Mental Health is also requiring the central office and the two state hospitals to develop a specific 3 year affirmative action plan.

F. ADMINISTRATION OF 314(d) FUNDS

Section 314(d) of the Public Health Service Act, as amended, provides for the allocation of formula funds to states to "provide and strengthen public health services." Fifteen percent of Colorado's annual allotment is made available to the Division of Mental Health (DMH) for mental health services. Up to thirty percent of the DMH allocation will be used for administration of the program. The balance of the mental health funds will be utilized in accordance with federal guidelines with particular attention to:

1. projects designed to eliminate inappropriate placement in institutions of persons with mental health problems;

2. the development of alternatives to institutionalization;

3. improving the quality of care of those for whom institutional care is appropriate;

4. assistance to agencies to facilitate pre-screening of residents being considered for inpatient care to determine if such care is necessary;

5. provision of follow-up care by community mental health centers and clinics for residents of the state who have been discharged from mental health facilities;

6. high risk populations such as the poor and the elderly.

The highest priority for funding will be projects which are innovative, time limited, and which have a built-in evaluation component.

ORGANIZATIONAL CHART
DEPARTMENT OF INSTITUTIONS

FIGURE 1

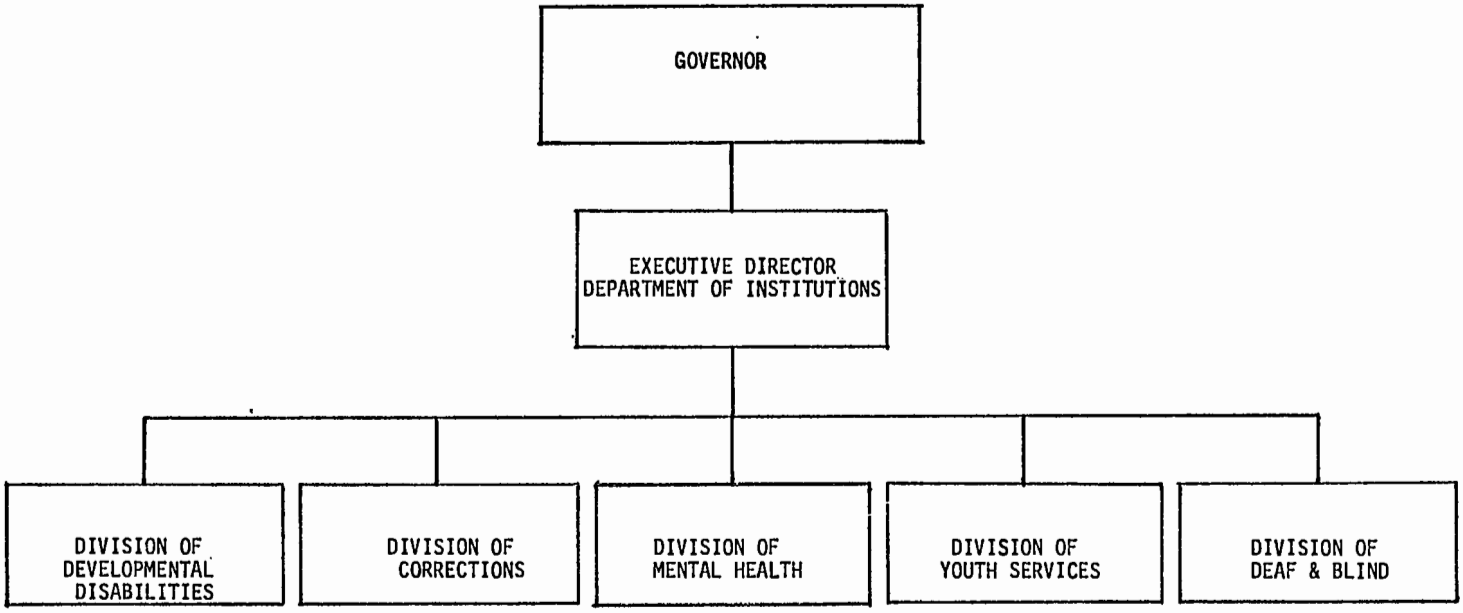
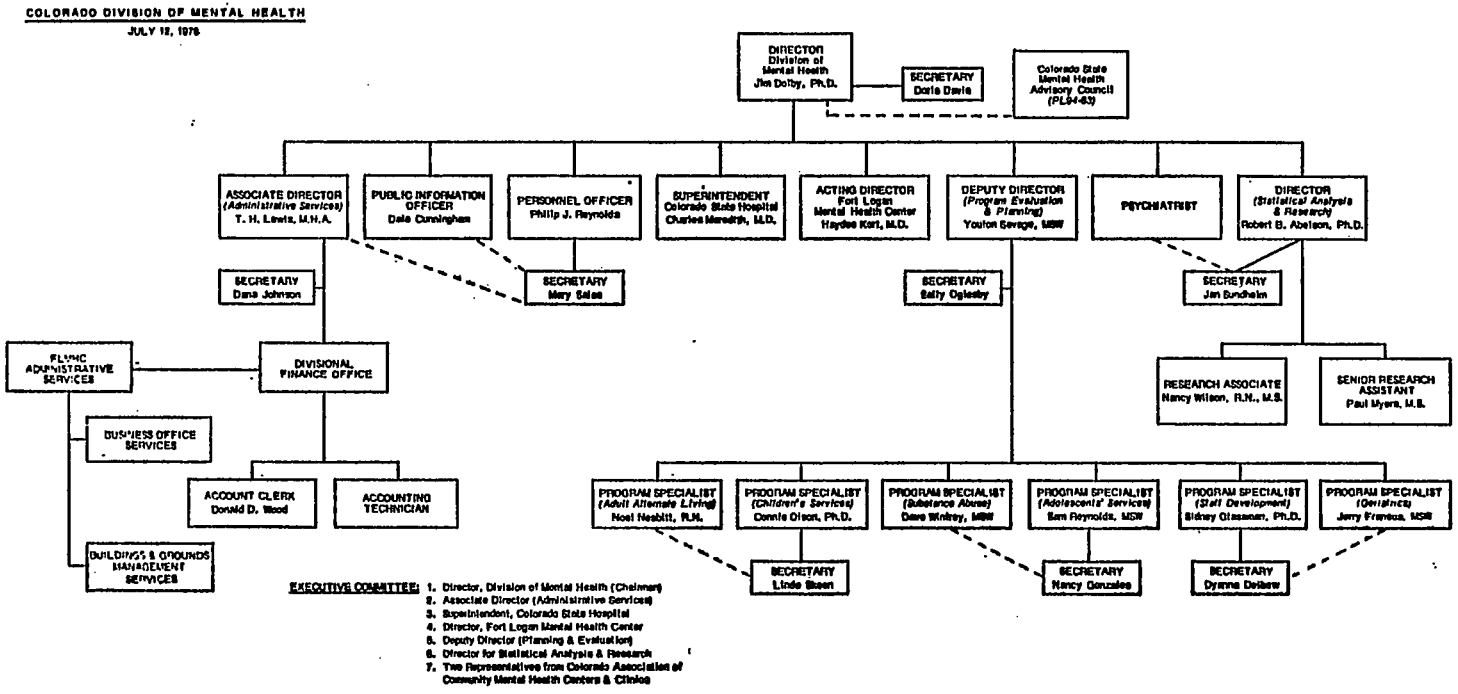


FIGURE 2


COLORADO DIVISION OF MENTAL HEALTH
JULY 15, 1976
DIRECTOR Division of Mental Health Jim Dolby, Ph.D.
SECRETARY Doris Davis
Colorado State Mental Health Advisory Council (PL94-63)
ASSOCIATE DIRECTOR (Administrative Services) T. H. Lewis, M.H.A.
PUBLIC INFORMATION OFFICER Dale Cunningham
PERSONNEL OFFICER Philip J. Reynolds
SUPERINTENDENT Colorado State Hospital Charles Meredith, M.D.
ACTING DIRECTOR Fort Logan Mental Health Center Haydee Kart, M.D.
DEPUTY DIRECTOR (Program Evaluation & Planning) Yvonn Savage, MSW
PSYCHIATRIST
DIRECTOR (Statistical Analysis & Research) Robert B. Abelson, Ph.D.
SECRETARY Dana Johnson
SECRETARY Mary Sales
SECRETARY Sally Oglesby
SECRETARY Jan Sundheim
FLMHC ADMINISTRATIVE SERVICES
DIVISIONAL FINANCE OFFICE
RESEARCH ASSOCIATE Nancy Wilson, R.N., M.S.
SENIOR RESEARCH ASSISTANT Paul Myers, M.S.
BUSINESS OFFICE SERVICES
ACCOUNT CLERK Donald D. Wood
ACCOUNTING TECHNICIAN
PROGRAM SPECIALIST (Adult Alternate Living) Noel Nesbitt, R.N.
PROGRAM SPECIALIST (Children's Services) Connie Olson, Ph.D.
PROGRAM SPECIALIST (Substance Abuse) Dave Winfrey, MSW
PROGRAM SPECIALIST (Adolescents' Services) Sam Reynolds, MSW
PROGRAM SPECIALIST (Staff Development) Sidney Glassman, Ph.D.
PROGRAM SPECIALIST (Geriatrics) Jerry Fransua, MSW
BUILDINGS & GROUNDS MANAGEMENT SERVICES
SECRETARY Linda Baen
SECRETARY Nancy Gonzales
SECRETARY Dyanna Dellare
EXECUTIVE COMMITTEE:
1. Director, Division of Mental Health (Chairman)
2. Associate Director (Administrative Services)
3. Superintendent, Colorado State Hospital
4. Director, Fort Logan Mental Health Center
5. Deputy Director (Planning & Evaluation)
6. Director for Statistical Analysis & Research
7. Two Representatives from Colorado Association of Community Mental Health Centers & Clinics

- III.1 -

III. STATEWIDE GOALS AND OBJECTIVES

A. GOALS

One purpose of the planning process is to develop procedures and mechanisms for managing the activities, tasks, and changes necessary to accomplish the mission and purpose of the organization. The setting of goals is both an essential element of the planning process and an important product. The goals in this chapter provide direction to the efforts of the public mental health system. The objectives which follow serve the dual functions of describing the steps necessary to accomplish the goals, and providing a means of assessing progress. These goals and objectives are to be our guidelines; however, they will be responsive to changing needs and other factors that evolve during the continuous planning process.

Woven into the fabric of the goals are the principles which undergird the state public mental health delivery system. These principles emphasize the provision of cost-effective services close to home, in the least restrictive setting, and in a manner which preserves human dignity, privacy and rights. The goals and objectives are the heart of the plan and serve as a unifying force which pulls together the various elements of the plan. These elements include need, special target populations, available and needed resources, coordination with other care-givers, the roles of the various components of the system, administration and accountability, and as previously indicated, the principles underlying the delivery of mental health services.

The goals and objectives are also in congruence with the congressional intent embodied in Public Law 94-63, the Community Mental Health Centers Amendments of 1975. This act focuses on: 1) the availability of a full range of mental health services (inpatient, partial hospitalization, outpatient, 24 hour emergency and consultation and education) in local communities; 2) special efforts to meet the mental health service needs of children, the aged, rape victims, and substance abusers; 3) pre-admission screening to reduce inpatient care; 4) the development of halfway houses and other alternatives to inpatient care; 5) follow-up care for persons who have been discharged from a mental health facility; and 6) services directed towards the prevention of mental illness.

The following comprehensive goals are interrelated and interdependent; therefore, the order of listing does not indicate relative priority.

1. Goal #1

> To provide mental health services through a system which:
> - is cost-effective
> - is coordinated with other agencies
> - is efficient
> - is based on the assessment of mental health needs
> - establishes and enforces quality of care standards
> - is evaluated.

The delivery of mental health services must be based on sound management principles which include determining what the needs are, obtaining the resources to meet these needs, providing effective services in the

most efficient manner and evaluating the impact of the services. Also necessary to this process are coordination with other agencies and the existence and enforcement of standards.

2. Goal #2

> To provide mental health services to the citizens of Colorado, emphasizing services which are:
> - least restrictive
> - community based
> - comprehensive
> - close to home
> - integrated
> - appropriate

The intent behind this goal is to provide services as close as possible to the client's home, in the most normal or home-like setting possible, and to emphasize utilization of the least intensive service consistent with the treatment needs of the client. The accomplishment of this goal requires:

a. recognition of the catchment area centers/clinics as the primary point of entry for clients entering the public mental health system;

b. pre-admission screening to insure that clients are not admitted to inpatient or another more intensive level of care than is required to effectively and efficiently treat them;

c. the development in each catchment area of the array of mental health services necessary to meet the service needs of the residents, including a range of alternatives to inpatient care for those clients who require 24 hour care, but not inpatient hospitalization;

d. the use of Fort Logan (the state hospital serving the Denver metropolitan area) for short term inpatient hospitalization of adults from the metropolitan Denver area in those instances where the cost of care in a general or psychiatric hospital is not competitive with the cost at Fort Logan;

e. the use of state hospitals for inpatient care for specialized inpatient services to children, adolescents and the aged who specifically require inpatient hospitalization;

f. the use of state hospitals and appropriate center/clinic services for clients requiring long term care; (This will obviously require the development of criteria to be used as the basis for selection of the appropriate treatment setting, and the movement of a client from one setting to another.)

g. the sharing of services among or between contiguous catchment area centers/clinics;

h. the provision of services through contractual or other formal arrangements with other local public, voluntary or private resources;

i. the continued use of Colorado State Hospital for the provision of adult inpatient services to the Pueblo area;

j. prior determination of the short-term adult inpatient average daily attendance for Fort Logan Mental Health Center and Colorado State Hospital to insure proper staffing of the treatment units.

In summary, this goal emphasizes the intent that the basic responsibility for the provision of mental health services rests with catchment area centers/clinics. Services will be provided in the local community whenever practicable. Inpatient services will be used only for those clients for whom inpatient services are clearly indicated.

Alternate treatment facilities, including skilled nursing homes, intermediate care facilities, residential care facilities, halfway houses, family care homes, and foster homes will be developed in the various catchment areas. The availability of these facilities and pre-admission screening are expected to reduce the inappropriate use of inpatient beds.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:

- children
- adolescents
- elderly
- alcohol and drug abusers
- rape victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- chronically disabled

The indicated groups have been targeted because of the need for specific programs to meet their unique mental health needs. Utilization reports indicate that children and adolescents and the elderly are underserved. Chicanos, the largest ethnic minority group in Colorado, require a range of services which take into consideration not only the cultural factors which affect all Chicanos, but the diversity of mental health needs within the Chicano population.

Appendix II is the report of the Chicano Mental Health Planning Symposium, which took place in Denver in January 1976. This report identifies a number of issues essential to the planning and delivery of mental health services to Chicanos. Many of the symposium recommendations are incorporated in this plan.

Other ethnic minority groups, while comparatively small in number, also have a right to expect some attention to be directed to the impact of their cultural heritage on their mental health service needs. Rape

victims, rural residents and women can be better helped in treatment programs which are sensitive to their unique needs. The poor, which are also represented in some of the other groups, are the highest users of public mental health services. Treatment programs which can identify their special needs and ways of addressing these needs are essential.

An almost neglected target population is the chronically disabled, many of whom are former state hospital inpatients. The intent is to insure that the chronically disabled are identified and provided the services necessary to improve their overall functioning to the fullest extent possible, and that every effort is expended to avoid hospitalization or re-hospitalization unless such care is specifically required.

4. Goal #4

> To increase public knowledge of mental health services and ways of preventing mental illness.

Preventive services are directed at the many potential victims of mental illness, i.e., that segment of the population which, while not visibly mentally ill, function below their potential capacities. The primary thrust of this goal is the promotion of mental health by helping people acquire knowledge, attitudes, and patterns of behavior which will foster and maintain their mental well-being. Prevention-oriented mental health education must take into account the make-up of the individual communities to be served, i.e., the proportion of aged, ethnic minorities, children, etc., and the most effective ways

of reaching these groups. In this connection, there is considerable evidence to support the contention that a prevention program based on the individual, family, and small group contacts, is an effective strategy to employ in the provision of services to Chicanos. This application of the prevention concept may, for many Chicanos, be more beneficial than traditional direct service methods. A major concern to be addressed is the lack of data on the impact of preventive programs.

5. Goal #5

> To increase consultation services to other public agencies that provide services to mentally ill persons.

The term consultation services, as used in this plan, applies primarily to assisting other community service professionals improve their skills in working with mentally ill persons. Community service professionals to whom consultation services are offered include school personnel, law enforcement officials, social service workers, court personnel, public health nurses, agricultural extension workers, clergymen, physicians, and others. These individuals are the "gate-keepers" of the mental health system, for in times of trouble they are the ones to whom the average person turns for help, and they account for the largest percentage of referrals to mental health service agencies. Obviously, the more skilled the "gate-keepers" are, the more effective they will be in early detection and early intervention. Possible outcomes of the involvement of skilled "gate-keepers" include the prevention

of some serious mental health problems and more appropriate referrals to mental health centers/clinics and hospitals.

B. OBJECTIVES

1. Goal #1

> To provide mental health services through a system which:
> - is cost-~~effective~~ efficient
> - is coordinated with other agencies
> - is efficient
> - is based on the assessment of mental health needs
> - establishes and enforces quality of care standards
> - is evaluated

a. Cost-Finding System:

(1) By July 1, 1976, a uniform Chart of Accounts for the two state hospitals will be developed.

(2) By January 1, 1977, a uniform cost allocation procedure (to include cost definitions and detail methods of allocation of all fixed, variable, and step variable costs) for the two state hospitals will be developed and implemented.

(3) By July 1, 1977, a system capable of generating comparable fiscal information needed for cost-finding in centers/clinics will be developed.

(4) By January 1, 1978, the system will be fully installed in all centers/clinics.

(5) By July 1, 1978, comparable cost-finding data will be available for all centers/clinics.

(6) By July 1, 1978, the cost finding systems for centers/clinics and the two hospitals will be comparable.

b. Audit Guidelines:

(1) By October 1, 1976, financial audit guidelines for centers/clinics will be developed.

(2) By October 1, 1977, the initial audit of all centers/clinics based on these guidelines will be completed.

c. Energy Conservation:

(1) By July 1, 1979, a total energy conservation study will be done at both state hospitals.

(2) By July 1, 1981, state hospitals will begin conversion to solar heating/cooling, if proven feasible by the energy conservation study.

d. Staffing Pattern:

(1) By July 1, 1977, a classification and salary survey of centers/clinics will be completed.

(2) By July 1, 1978, the recommended staffing patterns for the state hospitals will be based on management engineering principles and normative standards.

(3) By July 1, 1978, the recommended staffing patterns for mental health centers/clinics will be developed.

e. Treatment Outcome Evaluation:

(1) By March 1, 1977, a method for evaluating treatment outcome,

comparable for the total system, will be decided upon by the Division of Mental Health in consultation with the statewide Evaluation Advisory Committee.

(2) By July 1, 1977, this method will be implemented statewide.

(3) By July 1, 1978, comparable data regarding treatment outcome will be available from all agencies.

f. Coordination with Other Agencies:

(1) By September 1, 1976, quarterly meetings with representatives of the State Health Planning and Development Agency will begin.

(2) By September 1, 1976, quarterly meetings with the Department of Psychiatry, University of Colorado Medical Center will begin.

(3) By September 1, 1976, quarterly meetings with the Department of Social Services will begin. These meetings will deal with such issues as reimbursement for mental health services under Titles XVIII, XIX and XX of the Social Security Act, and other aspects of care to persons eligible for services reimbursable by social service funds.

(4) By October 1, 1976, the Division of Mental Health will begin providing the State Health Coordinating Council with information on mental health service needs and recommended programs for meeting these needs, on an annual basis.

(5) By November 1, 1976, periodic contacts will be established with the Department of Education and the Judicial Department to deal with areas of mutual concern, such as services to children and forensic issues.

(6) By January 1, 1977, periodic contacts with such divisions

of the Department of Health as family health services, community health services, administrative services, alcohol and drug abuse and health facilities will be initiated.

g. Need Assessment:

(1) By October 1, 1976, the Division of Mental Health will produce a catalog of programs offered by its agencies.

(2) By October 1, 1976, a methodology for performing a comprehensive need assessment will be decided upon.

(3) By March 1, 1977, an annual inventory of existing facilities, as required by the State Plan, will be performed.

(4) By March 1, 1977, an annual update of the personnel needs and resources of the mental health system will be accomplished.

(5) By July 1, 1977, need assessment data to be used for program planning and budgeting purposes will be available.

(6) By October 1, 1977, a comprehensive inventory of services offered by the Division of Mental Health agencies will be produced.

(7) By July 1, 1978, need assessment data will be further refined.

h. Standards and Evaluation:

(1) By July 1, 1977, the On-Site Evaluation Instrument will be reviewed and revised.

(2) By July 1, 1977, every center/clinic will be evaluated using the 1976 version of the On-Site Evaluation Instrument.

(3) By July 1, 1977, each center/clinic/hospital will have a written Quality Assurance Program and peer review mechanisms.

(4) By July 1, 1978, the first review and update of the revised State Standards/Rules and Regulations for centers/clinics will be accomplished.

(5) By July 1, 1978, the Division of Mental Health will have developed standards for hospitals to supplement JCAH standards.

(6) By July 1, 1979, the hospitals will be evaluated using these supplemental standards.

(7) By July 1, 1981, the State Standards/Rules and Regulations for centers/clinics will be completely revised.

(8) By July 1, 1981, the Division of Mental Health will require all centers to meet Joint Commission on Accreditation of Psychiatric Facilities Standards for Centers.

2. Goal #2

To provide mental health services to the citizens of Colorado, emphasizing services which are: - least restrictive - community based - comprehensive - close to home - integrated - appropriate

a. Use of Hospitalization:

(1) By July 1, 1977, the average daily attendance (ADA) at

the two state hospitals for FY 1976-77 will be six percent less than that for FY 75-76.

(2) By July 1, 1978, Fort Logan Mental Health Center will be established as the primary agency which provides adult inpatient services for the Denver metro area (except the Northwest Denver and Bethesda catchment areas).

(3) By July 1, 1978, the total ADA at the two state hospitals for FY 1977-78 will be seventeen percent less than that for FY 75-76.

(4) By July 1, 1979, the total ADA at the two state hospitals for FY 1978-79 will be twenty-eight percent less than that for FY 1975-76.

(5) By July 1, 1981, the ADA at the two state hospitals for FY 1980-81 will be thirty-eight percent less than that for FY 1975-76.

b. Center/Clinic-Hospital Integration:

(1) By January 1, 1977, the Division of Mental Health will form a joint center/clinic-hospital treatment planning group to formulate diagnostic, admission, treatment and discharge policies.

(2) By July 1, 1977, each center/clinic will have developed and implemented written procedures for the prescreening of potential inpatient admissions from social service departments, courts and other community agencies.

c. Services Close to Home:

(1) By July 1, 1977, the Division of Mental Health will develop in collaboration with appropriate agencies, proposed criteria and standards for admission to alternate treatment facilities.

(2) By July 1, 1978, all 14 current centers will have developed the full range of the 12 comprehensive services (inpatient, partial, outpatient, 24-hour emergency, consultation and education, pre-admission screening, halfway house, follow-up and services to children, the elderly, and alcohol and drug abusers). These services will be provided directly or through affiliated agencies.

(3) By July 1, 1978, at least eight of the catchment areas will each have available a minimum of five different types of residential treatment alternatives (e.g., nursing homes, intermediate care facilities, residential care facilities, halfway houses, family care homes, foster homes, etc.) to inpatient hospitalization.

(4) By July 1, 1978, all centers/clinics will provide follow-up treatment services to persons discharged from inpatient care who require such services.

(5) By July 1, 1979, at least 16 catchment areas will each have available a minimum of five different types of alternate treatment facilities.

(6) By July 1, 1979, all catchment areas will have 24-hour emergency care available.

(7) By July 1, 1981, the seven catchment area clinics will be comprehensive centers offering the 12 services. These services will be furnished directly or through affiliate agencies.

(8) By July 1, 1981, all centers/clinics will have available a minimum of five types of alternate residential treatment facilities.

d. Continuing Education:

(1) By July 1, 1976, a continuing education grant will have been developed for the training of center/clinic staff in the provision of the services required by PL 94-63 (inpatient, outpatient, partial care, consultation and education, emergency, prescreening, follow-up, halfway house services and services to children, the elderly and substance abusers).

(2) By October 1, 1976, the Division of Mental Health will begin providing training to mental health agencies in the delivery of consultation services to other care giving agencies.

(3) By January 1, 1977, the Division of Mental Health will have a proposed training program for increasing staff sensitivity to Chicano mental health needs.

(4) By January 1, 1977, the Division of Mental Health will designate for development one or more specialized, mental health resource centers for educational materials which would be available to all mental health agencies. The resource center will include special sections for educational materials on Chicanos and other groups with special mental health service needs.

(5) By May 1, 1977, the proposal for increasing staff sensitivity to Chicano mental health needs will have been field tested in at least three centers/clinics.

(6) By July 1, 1977, the Division will have three minority awareness training programs, including the program referred to in (4) above, available for agency use.

(7) By July 1, 1977, the Division will conduct the first of its training programs for the ongoing career development of clinical administrators.

(8) By July 1, 1977, the Division of Mental Health, with the assistance of the Continuing Education Committee, will establish standards for inservice and continuing education programs.

(9) By July 1, 1977, the Division will initiate a process for developing uniform definitions and training requirements leading to certification of employees for various levels, functions and roles in center/clinics.

(10) By July 1, 1977, the Division of Mental Health and the Division of Alcohol and Drug Abuse will have developed a training program for mental health agency staff who work with alcohol and drug abusers.

(11) By March 1, 1978, a training program for the training of parents to work in group homes will be developed.

(12) By July 1, 1978, the Division will have instituted a training program for persons who work with the chronically disabled.

(13) By July 1, 1978, the Division will have made available to each center/clinic a minimum of two board training sessions (baseline July 1, 1976).

(14) By July 1, 1979, the Division of Mental Health with the assistance of the Continuing Education Committee, will develop a proposal for the adequate funding of the training needs of the centers/clinics and hospitals.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:

- children
- adolescents
- elderly
- alcohol and drug abusers
- rape victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- chronically disabled

a. Children (Ages 0-11 years):

✓(1) By July 1, 1977, the proportion of admissions of children to the state mental health system during the 76-77 FY will be increased by 25 percent over that of the base year, FY 1974-75.

(2) By July 1, 1978, twelve centers/clinics will have professionals trained in the treatment of children.

(3) By July 1, 1978, all catchment area programs designated as centers as of that date will have a partial care program for children

if the need in the catchment area warrants such services.

(4) By July 1, 1978, the proportion of admissions of children during the 77-78 FY will be increased by 35 percent over that of the base year, FY 1974-75.

(5) By July 1, 1978, Fort Logan Mental Health Center will add an additional unit in the Children's/Adolescent Division.

(6) By July 1, 1978, at least one group home with specially trained house parents will be established in at least each of the six catchment areas with the greatest proportion of youth. (Adams, San Luis Valley, Arapahoe, Jefferson, Southwest Denver, Southeast Colorado)

(7) By September 1, 1978, twelve centers/clinics will have a home treatment program to work with children in their own homes.

(8) By July 1, 1979, all catchment area programs will attempt to have a written agreement defining their working relationships with the school district, day care, head start and other pre-school programs which receive public funds.

(9) By July 1, 1979, the proportion of admissions of children during the 78-79 FY will be increased by a minimum of 45 percent over that of the base year, FY 1974-75.

(10) By July 1, 1979, all centers/clinics will have professionals trained in the treatment of children.

(11) By September 1, 1980, all centers/clinics will have a home treatment team to work with children in their own homes.

(12) By July 1, 1981, all catchment area agencies designated as

comprehensive centers after July 1, 1978, will have a partial care program for children if there is a need for such services in the catchment area.

(13) By July 1, 1981, all catchment area centers/clinics programs will have at least one group home with specially trained house parents.

b. Adolescents (Ages 12-17 years):

✓ (1) By July 1, 1977, the proportion of admissions of adolescents to the state mental health system during the 76-77 FY will be increased by fifteen percent over that of the base year.

(2) By July 1, 1978, twelve centers/clinics will have professionals trained in the treatment of adolescents.

(3) By July 1, 1978, all catchment area programs designated as centers as of that date will have a partial care program for adolescents if justified by the number of adolescents requiring such services.

(4) By July 1, 1978, the proportion of admissions of adolescents during the 77-78 FY will be increased by twenty percent over that of the base year, FY 74-75.

(5) By July 1, 1978, at least one group home with specially trained house parents will be established in each of the six catchment areas with the greatest proportion of youth (Adams, San Luis Valley, Arapahoe, Jefferson, Southwest Denver, Southeast Colo.).

(6) By July 1, 1979, the proportion of admissions of adolescents during the 78-79 FY will be increased by a minimum of twenty five

percent over that of the base year, FY 74-75.

(7) By July 1, 1979, all centers/clinics will have professionals trained in the treatment of adolescents.

(8) By July 1, 1981, all catchment area centers/clinics will have at least one group home with specially trained house parents.

(9) By July 1, 1981, all catchment area centers and clinics will have a partial care program for adolescents if the number of adolescents requiring such services justifies a partial care program.

c. Elderly:

(1) By September 1, 1976, the Division of Mental Health will begin holding at least quarterly meetings with the Division of Services for the Aging with specific attention to the requirements and guidelines included in Public Law 94-63, the Community Mental Health Center Amendments of 1975, the Older Americans Act, and other federal and state statutes and directives which relate to services to the elderly.

(2) By September 1, 1976, the Division of Mental Health and the Division of Services for the Aging will begin actively promoting a state-wide field-level partnership between community mental health centers/clinics and area aging agencies with a view toward including a mental health services component in the information and referral systems of the area aging agencies, and coordinating local assessments of program needs as they relate to the elderly.

(3) By January 1, 1977, the Division of Mental Health will have begun to discuss with the Division of Services for the Aging, ways of reflecting in the FY 77-78 budget of both Divisions their joint efforts to assist older persons in maintaining themselves in independent living arrangements.

✓ (4) By July 1, 1977, the proportion of elderly persons admissions during the 76-77 FY will be increased by 50 percent over that of the base year, FY 1974-75.

(5) By July 1, 1978, the proportion of admissions of elderly persons during the 77-78 FY will be increased 100 percent over that of the base year, FY 1974-75.

(6) By July 1, 1978, at least six catchment area programs with the largest proportion of elderly in their population (Northwest Denver, Northeast Colorado, East Central, Southeast Colorado, Midwestern, West Central) will have independent living groups, group homes, transportation networks, home industries, etc. to minimize the need for nursing home care. These services need not be directly furnished by the mental health center/clinic, but can be provided by other community agencies with support from the mental health agency.

(7) By July 1, 1980, all catchment areas will have independent living groups, group homes, transportation networks, home industries, and other similar services.

(8) By July 1, 1981, the proportion of admissions of elderly persons during the 80-81 FY will be increased by 200 percent over

that of the base year, FY 1974-75.

d. Alcohol and Drug Abusers:

(1) By August 1, 1976, the Division of Mental Health (DMH) and the Division of Alcohol and Drug Abuse (DADA) will have established a work group to address the problems in coordinated service delivery identified by each Division.

(2) By September 1, 1976, DMH and DADA will have entered into an agreement concerning coordinated on-site evaluations of alcohol and drug abuse programs at mental health centers, clinics and hospitals.

(3) By September 1, 1976, the DMH and DADA will have coordinated procedures for the use of admission forms and program data.

(4) By October 1, 1976, DADA will have developed, in collaboration with DMH, a process for insuring input into the state alcohol and drug abuse plan by mental health centers and clinics, the two state hospitals, the Division of Mental Health central office, and vice versa.

(5) By January 1, 1977, the DADA-DMH work group will present a report to the Human Services Policy Council and the State Health Coordinating Council on the proposed procedures and mechanisms for overcoming problems in coordinated service delivery.

(6) By July 1, 1977, the DMH and DADA will have jointly developed guidelines for providing appropriate alcohol and/or drug abuse services to clients of the mental health system,

and for providing appropriate psychiatric services to clients of the alcohol and drug abuse service system.

e. Rape Victims:

(1) By July 1, 1977, Colorado State Hospital (CSH) will institute a limited pilot program to identify and evaluate treatment techniques for the rehabilitation of rape offenders.

(2) By July 1, 1977, all catchment area programs will be offering consultation and education services directed toward the prevention of rape, using information from the Denver Department of Health and Hospitals (DDHH) program and other sources.

(3) By July 1, 1977, information on the techniques for treatment of rape victims and their families from the DDHH study and other sources will be available in each center/clinic and both state hospitals.

(4) By July 1, 1979, if warranted by the results, information from the CSH pilot program for rape offenders will be made available to correctional and other appropriate agencies and facilities in the state.

f. Ethnic Minorities:

(1) By January 1, 1977, the Division of Mental Health will form a talent bank of minority mental health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos, Blacks, Native Americans, and Asian Americans. This group will

develop a mechanism for the exchange of expert technical information in minority services, and make recommendations regarding programs to meet the special mental health needs of ethnic minority groups.

(2) By January 1, 1977, the Division of Mental Health will be actively soliciting funds for special research and demonstration projects to determine special treatment needs of ethnic minorities and techniques for most effectively meeting these needs.

(3) By January 1, 1977, the DMH will conduct a study of the staffing pattern of each center/clinic to determine how these correlate with the ethnic and sex proportions in the client and general population.

(4) By April 1, 1977, the results of the study of the ethnic and sex makeup of center/clinic staffs will be made available to the agencies concerned for use in updating affirmative action plans.

(5) By July 1, 1980, information from the special research and demonstration projects for Chicanos, Blacks, Native Americans and Asian Americans will be reflected in the services provided by centers/clinics and hospitals.

g. Rural Residents:

(1) By July 1, 1977, the DMH will form an ad hoc committee which will identify the special mental health service needs of rural residents, the continuing education needs of mental health agency staff who serve them, and ways of effectively meeting these needs.

(2) By May 1, 1978, the report of the ad hoc committee will be available for consideration for special funding in the FY 1979-80 budget and for dissemination to appropriate agencies.

h. Economically Disadvantaged Persons:

(1) By July 1, 1976, the Division of Mental Health will use poverty resources as a major criteria for setting priorities for funding mental health agencies in Colorado.

(2) By October 1, 1976, all centers/clinics will be required to identify and prioritize the areas of poverty in their catchment areas and to indicate the efforts made, and plans to serve, these high risk populations.

(3) By October 1, 1976, DMH staff will begin meeting with appropriate State Department of Social Services and Regional Department of Health, Education & Welfare staff to explore means of increasing the availability of funding (via Medicare, Medicaid and other Social Service programs) for mental health services to the poor. The results of these meetings will be appropriately disseminated.

i. Women:

(1) By January 1, 1977, the DMH will form an ad hoc committee to gather information relating to the mental health service needs of women and ways of effectively meeting these needs. This information will be disseminated to centers/clinics and hospitals.

(2) By July 1, 1977, all centers/clinics and state hospitals which

do not have treatment programs appropriate to the special mental health needs of women will be required to develop and document such a program.

j. Chronically Disabled:

(1) By January 1, 1977, each catchment area agency will have made specific and documented efforts to identify chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

(2) By July 1, 1977, each catchment area agency will have begun providing services to chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

4. Goal #4

To increase public knowledge of mental health services and ways of preventing mental illness.

(1) By July 1, 1976, the DMH central office will issue monthly releases to the media on various mental health issues.

(2) By July 1, 1976, the Division of Mental Health will begin to offer consultation to one mental health agency per month on various ways of reaching the public.

(3) By July 1, 1977, the Division of Mental Health will have begun to conduct one joint public information activity with the Mental Health Association of Colorado each year.

(4) By July 1, 1977, mental health centers/clinics will be requested

to provide periodic releases to local news media on various health issues.

(5) By July 1, 1977, the DMH will invite centers/clinics to submit proposals for innovative preventive programs and evaluation of these programs. At least one proposal will be approved for funding with 314(d) funds.

(6) By January 1, 1978, all mental health centers/clinics will be required to conduct or sponsor each year, at least one seminar, workshop or other public program which focuses on the prevention of mental illness.

(7) By July 1, 1978, the DMH will initiate an assessment of consultation and education services.

5. Goal #5

To increase consultation services to other public agencies that provide services to mentally ill persons.

(1) By October 1, 1976, the DMH will offer periodic consultation services to Department of Health divisions (e.g., family health services, community health services, alcohol and drug abuse) which request such services.

(2) By January 1, 1977, the DMH will offer periodic consultation services to the Department of Social Services, the Judicial Department, and the Department of Education.

(3) By January 1, 1977, all centers/clinics will have been requested

to have at least one information sharing/mutual consultation session with public health nurses and other appropriate public health personnel concerning areas of shared responsibility and coordination of health services.

(4) By January 1, 1977, all centers/clinics will have been requested to have at least one information sharing/mutual consultation session with the regional alcohol and drug abuse coordinator.

(5) By January 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with county social services personnel to discuss mutual concerns and ways of improving services to mutual clients.

(6) By March 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with school district staff and district and other court personnel.

(7) By January 1, 1978, all centers/clinics will be required to have periodic information sharing/mutual consultation sessions with public health nurses and other appropriate public health personnel, regional alcohol and drug abuse coordinators, court personnel, school district(s) staff, social services staff and staff of other appropriate human services agencies in the catchment area such as clergymen, law enforcement agencies, etc.

IV. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

The Colorado public mental health system consists of two state hospitals, both of which are fully accredited by the Joint Commission on Accreditation of Hospitals, twenty-one mental health centers and clinics, each of which serves a defined catchment area, and three specialty clinics. The Department of Institutions is the statutory authority for the provision of mental health services to the citizens of the State of Colorado. The Department of Institutions has delegated to the Division of Mental Health the authority to operate the two state hospitals, to purchase services from community mental health centers and clinics, and to otherwise plan for and direct the mental health program.

Division of Mental Health

The Division of Mental Health exercises the following responsibilities.

1. Planning

This includes determining need, initiating plans and/or responding to new state or federal legislation which requires statewide mental health planning efforts.

2. Coordination

This involves the facilitation of cooperative activities among and between components of the Colorado mental health services delivery system and other human service agencies to meet the various mental health service needs of the residents of the state.

3. Executive Direction

The exercise of authority as an agent of the State Executive, including the establishment and enforcement of policies, rules and regulations is encompassed in this responsibility.

The Division of Mental Health (DMH) staff includes six Mental Health Program Specialists whose primary responsibility is monitoring the programs and services of the state hospitals and centers and clinics to ensure compliance with standards and to assist the agencies in improving services. Other DMH staff also perform general monitoring functions. The primary program monitoring staff consists of one nurse, three social workers and two psychologists, all of whom have clinical and administrative experience.

4. Consultation

This would provide for consultation on planning, clinical programming, funding and evaluation to all components of the system, to the Governor's office and other state offices and agencies.

5. Evaluation and Accountability

This includes providing necessary leadership in the development of a methodology for measuring the impact of treatment and prevention efforts and relating this to cost.

6. Advocacy

Advocacy involves initiating and promoting the development of mental health programs to serve the needs of all residents of the state.

The client advocacy function includes:

a. requiring agencies to make services available to all who require mental health services, regardless of race, sex,

religious beliefs, age, level of disability, etc., and requiring agencies to provide services in a manner which takes into consideration cultural and other variables;

b. publication of a handbook on patient's rights and responsibilities which sets forth the legal rights of patients; (A copy of this document, which will be in final form within two months, will be made available to each state hospital inpatient.)

c. the establishment of a grievance mechansim which includes the availability of a designated patient advocate in each state hospital and staff assistance to clients who wish to contact legal aid organizations or private counsel.

The service facilities which comprise the spectrum of available services including the public private/voluntary sectors are identified as follows:

Public Treatment Facilities

a. Colorado State Hospital (CSH) which is located in Pueblo, serves forty-seven counties in the southern and western portions of the state.

b. Fort Logan Mental Health Center (FLMHC) is located in southwest Denver. It serves the Denver metropolitan area and northeastern Colorado. As of July 1, 1976, FLMHC will also serve six counties in north-central Colorado.

c. There are twenty-four mental health centers and clinics from which the state purchases mental health services. Fourteen centers and seven clinics serve specific catchment areas and

three clinics are specialty programs. A center is defined as an agency which provides the five "essential" services (inpatient, partial hospitalization, outpatient, 24-hour emergency care and consultation and education). By local definition, a clinic provides fewer than the five essential services, but generally at a minimum, outpatient, consultation and education and emergency services. In actuality, some "clinics" provide the same services as some centers, but have not been funded. All centers and clinics are private, non-profit corporations except the Larimer County Mental Health Clinic and Northwest Denver Mental Health Center, both of which are county agencies.

d. Colorado Psychiatric Hospital is located in Denver on the University of Colorado Medical Center campus.

Private/Voluntary Treatment Resources

a. Three private psychiatric hospitals and over a score of private general hospitals which have psychiatric wards or which will accept psychiatric patients exist.

b. 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.

c. Private practitioners (nurses, social workers, psychologists, pastoral counselors, psychiatrists, etc.) form a multitude of resources.

d. 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) public 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) 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.

B. PRE-ADMISSION SCREENING

1. Role of Hospitals and Centers and Clinics

Mental health centers and clinics, CSH and FLMHC are engaged in pre-admission screening. In those catchment areas where centers and clinics have well established relationships with courts, social service departments and other community agencies, most of the pre-admission screening is carried out by the catchment area center or clinic. In other areas, some pre-admission screening is accomplished by CSH and FLMHC. Many clients are entering state hospitals without pre-admission screening.

The DMH policy is that persons entering the mental health system are, to the maximum extent possible, to enter through the catchment area center or clinic. The intent is to have the pre-admission screening

function take place in the local community. Primary emphasis is on the provision of the necessary services as close to the individual's home as possible and in the least intensive setting consistent with the individual's clinical needs.

Some types of clients referred directly to CSH and FLMHC include children, adolescents, elderly, seriously disturbed adults who appear to require inpatient care and, in the case of CSH, forensic clients or the "criminally insane." CSH has statutory responsibility for forensic clients. Both state hospitals' roles currently include inpatient services to persons in the four age groups (children, adolescents, adult, elderly). However, it is believed that some of the children, adolescents, adults and elderly persons referred for inpatient care could and should receive outpatient care or treatment in an alternate treatment facility in the local community. In order to reduce inpatient admissions, the procedures outlined in Section 2 which follows are being implemented.

2. Procedure for Pre-Admission Screening by Centers and Clinics

   a. All catchment area centers and clinics will inform the district courts, social service departments and other major referral sources in the catchment area of the center's/clinic's responsibility for pre-admission screening of all potential inpatient clients.

   b. Each catchment area agency shall develop a written procedure for pre-admission screening and distribute the procedures to appropriate agencies. The criteria for admission to inpatient care will take into consideration:

(1) the persons physical health; e.g., if there are such medical problems as uncontrolled diabetes, arteriosclerosis, etc., as determined by a physician, inpatient or skilled nursing home care might be indicated;

(2) the seriousness and nature of the pathology; e.g., a client who is blatantly schizophrenic and dangerous to himself/herself might be hospitalized or placed in a secure non-hospital setting;

(3) current and past medication need and drug use; e.g., if an individual requires or has been using drugs (licit or illicit) of a type or in an amount which requires a period of observation or stabilization, a more intensive form of care might be indicated;

(4) the adequacy of the individual's social support system; e.g., an individual who lives alone and has no relatives or significant others to call upon, might in a time of emotional stress require a supervised treatment setting;

(5) age and maturity; e.g., does the individual need to be in a specific setting because of precocious or retarded development;

(6) other factors; e.g., previous medical and/or psychiatric history, financial circumstances and the availability of less restrictive alternatives, etc. should be considered.

The decision regarding the type or locus of treatment is basically a clinical judgement. In that by state statute, the treatment program must be under the overall direction of

a physician. The responsible physician in each agency will designate, to perform pre-admission screening functions, those staff members who have the requisite training, skill and experience.

c. The written procedure shall designate a primary agency contact person and a back-up contact person for pre-admission screening.

d. Appropriate reports shall be provided the requesting agency, and proper documentation shall be maintained by the center/clinic.

e. If the client is admitted to the center/clinic, he/she will be asked to sign a release of information form which will authorize the obtaining of appropriate information from other agencies and the release of appropriate information to agencies which need such information in the interest of the client. (Note: The Care and Treatment of the Mentally Ill Act permits the exchange of information on certified individuals by "professional persons.")

f. In those instances where a person who should have been evaluated by a catchment area center or clinic bypasses the center/clinic and appears at CSH or FLMHC to be admitted, the hospital may refer the individual to the appropriate center/clinic, or if clinically or otherwise appropriate, the person may be admitted to the hospital. If the person is admitted, the hospital will ask the client to sign a release of information form and notify the appropriate center/clinic of the admission. The center/clinic will contact the agency which directed the client to the hospital to clarify the referral process.

All catchment area centers and clinics (see Chapter VI, Section C) are designated the pre-admission screening agency for their respective catchment areas.

C. ALTERNATIVES TO HOSPITALIZATION

1. Need Within Each Catchment Area

Each community mental health center/clinic has the responsibility for ascertaining on an ongoing basis the need for alternatives to both hospitalization and other forms of institutionalization within its catchment area. A survey of existing resources should be conducted as cooperative effort between such agencies as: the social services department of each county within the catchment area; developmental disability agencies such as the community centered boards; county health departments; courts; and private placement agencies.

2. Responsibility for Developing Alternatives

The primary responsibility for developing alternatives to hospitalization for mental health clients and/or potential mental health clients rests with centers and clinics. The two state hospitals have experience and expertise in this area and should be consulted. Alternatives assessed for potential use by mental health clients should emphasize the least restrictive alternative principle. In addition to the continuum of community based "institutional" programs which includes local psychiatric hospitals, psychiatric wards of general hospitals, nursing homes, etc., alternatives to institutionalization including sheltered workshops with supportive living

arrangements, family care homes, supervised boarding homes, group living homes, foster homes and a variety of other non-institutionalized facilities and services are being utilized. Additional such facilities are needed. Other community resources which are to be appropriately utilized include the facilities of such agencies as Human Services, Inc., Catholic Social Services, Lutheran Social Services, Jewish Family and Children's Services, as well as Vocational Services and other sections and divisions of the Department of Social Services.

3. Efforts to Develop Alternatives to Hospitalization

Intensive efforts to develop alternatives have been mounted in a number of communities. One county (Arapahoe) passed a bond issue to obtain a facility; another agency (Adams County Mental Health Center) developed boarding and sheltered workshop facilities with its own resources, then allowed the facility to become a private corporation from which it now purchases services. Still another center (Southwest Denver) has developed a series of family care homes which it uses in lieu of inpatient beds. Other centers have contracts and affiliation arrangements with boarding and nursing homes, as well as agreements for the use of other types of non-hospital alternatives.

4. Responsibility for Information and Referral Services in Each Catchment Area

Each catchment area program is responsible for providing information and referral services in the catchment area. Such services should be coordinated with the local United Way agencies and other human service organizations and groups.

D. PUBLIC MENTAL HOSPITALS

State mental hospitals began a new era in 1961 when Colorado State Hospital (CSH), then eighty-two years old, began a radical reorganization which saw it change from an overcrowded human warehouse with six thousand ill cared for clients, to a progressive treatment-oriented human services center. In the same year, Fort Logan Mental Health Center (FLMHC), a state hospital which was to pioneer many advances in mental health care, was organized. Both hospitals played important roles in the development of the state's community mental health centers.

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources

   a. Living Conditions

      The physical environment at FLMHC consists of spacious, airy buildings divided by patios and lawn areas. The architectural style of FLMHC has served as a model for other psychiatric hospitals throughout the county. The patient units contain single, two and four bed accomodations with adequate individual closet and drawer space for personal belongings of the patients. All patients wear their own clothing and have access to the clothing lab to select additional wearing apparel as needed. Funds are available to meet personal needs of patients who have no other resources.

The campus of FLMHC consists of 270 acres and includes many state and community programs, in addition to psychiatric programs as follows: Central Office for the Department of Institutions, including Executive Director's Office, Division of Mental Health, Division of Corrections; Division of Developmental Disabilities and Division of Youth Services; Intergovernmental Personnel Training Program, a division of the State Personnel Department; two CHINS Homes (Arapahoe County program); offices for the Colorado Corrections Association; Community Corrections Residential Program (a program sponsored by Adult Parole.)

b. Treatment Resources Available

Fort Logan has multi-disciplinary teams which are responsible for planning and delivering psychiatric treatment. Disciplines represented on teams or available for consultation include social workers, psychiatric nurses, psychiatrists, occupational therapists, psychologists, recreational therapists, teachers and mental health workers. Vocational rehabilitation services are provided by vocational counselors, largely through funding from the Division of Vocational Rehabilitation of the Department of Social Services.

A variety of expertise in various new and traditional psychotherapy techniques exists among center staff. Both group and individual psychotherapy are utilized. Chemotherapy is available as prescribed by the team psychiatrist. Electroshock is used sparingly and no psychosurgery has ever been prescribed.

Adequate financial resources are needed to maintain the treatment programs and provide sufficient staff to meet the needs of a seriously disabled client population. Constant effort at all levels of the system is important to avoid the hospital being used as simply a depository for some of society's problems.

2. Efforts to Improve Quality of Institutional Care

   a. In March 1975, Standards of Quality Treatment Services were issued describing: (1) context of the treatment program; (2) patient care; (3) treatment program; and (4) discharged planning or transfer.

   b. Treatment Review Committee, an interdisciplinary group, was established by the above policy and formally reviews the required, individualized treatment plans in charts with written documentation to supervisors about treatment practices, standards and alternative approaches of equal or greater effectiveness in such or related cases. This feedback raises the awareness of treatment staff and is directed towards improved quality of treatment.

   c. The Medical Records Committee has responsibility to review proposals for changing the medical record, for reviewing deficiencies, for auditing the quality of documentation of medical information and assessing training and consultation needs of clinical staff.

   d. The Utilization Review and Audit Committee is responsible for conducting special audit studies and concurrent review to

meet the Standards of Care Review established by the Colorado Department of Health, an external licensing body, Joint Commission on Accreditation of Hospitals (JCAH), Professional Standards Review Organization (PSRO), Medicare, Medicaid, Civilian Health and Medical Program of the United States (CHAMPUS) and other third party payors. This Utilization Review and Audit Committee also is responsible for reviewing the variations concerning patient care and staff responsibility for standards of care. Medical Care Evaluation Studies required by PSRO through the Colorado Medical Foundation are in progress.

e. The center has established a full-time position for a Patient Representative who is available to patients for discussing their concerns about the quality of care and acts as a factor in remedying of the identified problem. The Patient Representative is accountable to the Clinical Director.

f. The Professional Discipline Chiefs of various professional groups (psychiatrists, psychologists, social workers, nurses, activity therapists, mental health workers, vocational counselors, pastoral counselors and alcoholism counselors) within the center have major responsibilities for standards of professional practice related to quality of patient care, for supervision of and consultation with members of their discipline and others.

g. Inservice training programs are available to all staff through the Division of Hospital Standards and Inservice Training.

A special focus of inservice training over the last few years has been on interethnic and sex role awareness to implement the center's affirmative action plan. Sensitivity to these issues increases staff ability to work effectively with people of different backgrounds. In addition, a climate has been fostered which encourages staff to participate in extramural programs to learn and upgrade skills. Problem-Oriented Records have recently been instituted in some units after inservice training of staff in this process. The aim of such records is to provide quality of patient treatment through improvement of documentation. The goal is to move quickly towards use of this method in all patient divisions.

h. The Program Information Analysis Department reviews program operations and goal accomplishment in patient treatment providing data and feedback to administration and clinical staff about the treatment program.

i. The use of the problem/goal-oriented record system requires the setting of specific treatment goals and the evaluation of the progress made in accomplishing the goals.

3. Description of Present Fort Logan Mental Health Center Population

Fort Logan Mental Health Center is organized to provide treatment to children, adolescents, adults, geriatric patients and alcoholics who have severe behavioral and functional disorders. A mental health service has been established for deaf and hearing impaired persons in the Denver metropolitan area.

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Since its beginning in 1961, the Fort Logan Mental Health Center has had a basic commitment to short-term intensive treatment and early return of the patient to community living. This has resulted in the population receiving not only inpatient care, but graduated intensities of care in transitional living facilities on grounds and living in the community. Specialized programs provide long-term maintenance and support to many patients in community living situations who formerly would have remained in the hospital. For the first half of the current fiscal year (1975-76), the average daily attendance of this inpatient population was:

PROGRAM DIVISION	REQUIREMENTS FOR ADMISSION	ADA
Adult Psychiatric	Severe psychiatric disability	57
Alcoholism	Severe drinking problem	34
Children/Adolescent	Severe psychiatric illness	37
Geriatric and Deaf	Severe psychiatric illness	18
	FLMHC Total Inpatient Population:	146

In addition to inpatient beds, FLMHC also has ninety-four beds in on-grounds transitional living facilities.

Fort Logan serves sixteen counties, including the metropolitan Denver area and northeast Colorado. Beginning July 1, 1976, Fort Logan will also serve six counties in north-central Colorado. The major portion of the population served resides in a highly urbanized area within 20-30 miles of the hospital.

Within the area served by the hospital are nine community mental health centers and five community mental health clinics. Short-term, acute care for adults is provided in local communities whenever possible.

The hospital provides acute care for adult patients from northeast Colorado, Arapahoe County and on contract with some local centers. Currently, the basic responsibility of FLMHC is specialized inpatient services to children, adolescents, adults, geriatrics, alcoholism and long-term care for the chronically ill in programs designed to avoid institutionalization.

4. Plans for Avoiding Chronicity

The most important factor in avoiding chronicity is the availability of high quality treatment for the client. Intensive short-term hospitalization, maintenance of the person's ties to the social and cultural community of choice and early return to community living helps avoid chronicity. The FLMHC has attempted to develop multiple levels of care so clients can move toward increasing independence. In addition, FLMHC has supported and encouraged in every way possible development of adequate accessible community based services which emphasize prevention and early, effective intervention. The FLMHC vocational services program is a particularly excellent example of the hospital's efforts to avoid or limit chronicity.

5. Plans for Providing Social and Recreational Stimulation

The treatment philosophy of the FLMHC is based on rehabilitating and developing social skills as a part of the treatment of people admitted. The total treatment process recognizes and encourages social interaction as a basic therapeutic strategy. The Activity Therapy Program focuses on the growth potential of the client through activities and recreational programs. Most treatment teams have an activity therapist (academically trained as an occupational or

recreational therapist), who is responsible for both schedules and spontaneous activities. Clients utilize community facilities for swimming, bowling, movies, etc. This acquaints the client with the community and increases the likelihood that interest will continue after hospitalization. Cultural activities such as the theatre, arts and musical events are available and offer opportunities for clients to develop new interests. Active participation in camping, sports and games is encouraged. Instruction and materials are available for a wide range of craft projects such as macrame, ceramics, leather work and other crafts. The activity therapist also joins other treatment staff in improving daily living habits related to eating, grooming, manners and socializing. These help prepare the client for return to the community with an acceptable level of social skills.

Social and recreational programs are also available to clients who are not in the hospital setting, i.e., clients in boarding homes, nursing homes or other community living situations. Tickets for social and cultural events are made available, and where possible, the activity therapists links the patient into a community resource where social and recreational programs are available.

6. Evolving Role of Fort Logan Mental Health Center in the Mental Health Service Delivery System

It is planned that over the next five year period the FLMHC will evolve into the role of the primary provider of short-term inpatient care for the catchment areas in the Denver metroplex, with the centers and clinics having input into admissions and treatment policies and discharge decisions (with the exception of Bethesda and Northwest

Denver Mental Health Centers which have hospital beds immediately available to them). The adult inpatient average daily admissions is expected to decline over the next five years as pre-admission screening becomes more effective and additional alternative treatment facilities are developed. FLMHC will continue to provide long-term adult inpatient care for its catchment area, as well as geriatrics inpatient services. The Children/Adolescent Division will increase its inpatient services, and the Vocational Services and services for deaf and hearing impaired persons will expand. The alcohol abuse treatment program will be phased down to a level to be determined by the Divisions of Alcohol and Drug Abuse and Mental Health. FLMHC will continue to operate its on-grounds and community-based alternatives to inpatient care such as tertiary aid and prevention, the Lodge, supervised boarding homes, etc., as regional facilities until adequate alternate treatment facilities are available in the various catchment areas.

Colorado State Hospital

1. Description of Living Conditions and Treatment Resources

   a. Living Conditions

      The physical facilities meet all standards of local, state and national authorities, and are fully accredited by JCAH. Bedrooms range in size from single to six-bed units, with four-bed units being the most typical arrangement. All wards open to a central nursing station and lounge area furnished with social and recreational equipment.

Clients are provided with individual storage space for their personal effects, adequate clothing if they do not have their own and an allowance for personal items. Both staff and clients are encouraged to decorate rooms and halls to help create a pleasant atmosphere. The spacious grounds surrounding the hospital buildings are available to those clients who wish to and are able to take advantage of them.

b. Treatment Resources Available

Psychiatric treatment is planned and delivered by a multi-disciplinary team of well-trained professionals and para-professionals. These include psychiatrists, psychologists, social workers, occupational therapists, recreational therapists, teachers, psychiatric nurses, mental health workers and licensed psychiatric technicians. The hospital does not employ nursing attendants.

The Division of Vocational Rehabilitation (Colorado Department of Social Services) operates a rehabilitation service center on the hospital grounds and has assigned counselors to each program division to work with clients (and assist hospital staff) in developing individual educational and vocational programs.

Educational opportunities available to patients include a General Education Development Program, hospital staff teachers on several divisions, a fully accredited academic school in the Children's and Adolescents' Center and enrollment in public schools or the University of Southern Colorado in Pueblo.

Treatment modalities used throughout the hospital include individual and group psychotherapy, utilizing all modern techniques ranging from transactional analysis and Gestalt therapy to behavior modification and biofeedback, occupational and recreational therapy and vocational services in addition to chemotherapy. Clients benefit from the therapeutic milieu, as well as individual attention. Due to the wealth of therapeutic techniques available, it has been possible to use electroshock sparingly and only in short regimes. Psychosurgery is not used at all.

2. Efforts to Improve Quality of Institutional Care

a. Quality Assessment Program (QAP)

This is a CSH organized Professional Standards Review Organization (PSRO) type system operated by the Hospital Superintendent and Executive Committee. The plan is to seek full delegation of review authority from the Colorado PSRO. QAP efforts are in four main areas:

(1) admission certification Within one working day of admission, one hundred percent review of admissions for: appropriateness of admission and assigned level of care according to ten critical clinical and social criteria; and justification of diagnosis and codability. Incomplete or inadequate documentation is investigated, referred to a physician advisor when necessary and corrective action is initiated.

(2) concurrent review Covers one hundred percent of Medicare, Medicaid and Civilian Health and Medical Program of the United States (CHAMPUS), plus admissions and reviews of other third party admissions. Additionally, a minimum of a thirty percent random sample of all inpatient treatment episodes are reviewed on the 16th, 45th, 75th day and every 90 days thereafter for adequacy and quality of the "data base," treatment plan, related progress notes, release plans, length of stay justification and appropriateness of level of care and treatment intervention.

(3) inservice training Instruction on the Department of Health, Education and Welfare (DHEW) and Joint Commission on Accreditation of Hospitals (JCAH) standards and regulations, training for admitting physicians and other admissions staff includes review of admission criteria, diagnosis, presenting complaints, mental status exams and pertinent physical findings. Staff of treatment teams receive instruction on formulation and update of individualized comprehensive treatment plans which include goals, release plans, problems and assets, treatment objectives and planned interventions. All clinical staff receive training on the recording of progress notes with attention to adequacy and quality of the documentation related to the treatment plan, client's progress and treatment outcome.

(4) input to hospital policy decisions on records, formats, quality of care standards, procedures and corrective action on cases or patterns of non-compliance.

b. Medical Care Evaluation Studies

These are conducted at least once per year in each program division per PSRO and JCAH requirements.

c. Psychiatric Care Audit and Utilization Review Committee

This committee is comprised of representatives of all disciplines and program divisions of the hospital. It acts as third level reviewer of all cases and policy questions referred from the QAP, physician advisors, physician panelists and the natural and unnatural death committees. It reviews both cases and patterns of non-compliance and recommends policy or corrective action to the medical staff, hospital administration or other appropriate hospital committees.

d. Continuing Education

Each program division has its own education committee and engages in almost continuous inservice training for teaching new therapeutic techniques or improving clinical skills. Periodic hospital-wide workshops and seminars are provided to improve clinical skills. Heads of each clinical discipline hold departmental meetings to improve professional standards and clinical performance. Employees are encouraged to pursue additional academic education and financially supported when available funds permit. A special committee on continuing education is now at work developing programs for continuing education credit for licensure requirements of the various disciplines.

3. Description of Present Residential Population

The hospital groups its residents according to their functional requirements for specialized environments and clinical or rehabilitation techniques. These groupings constitute the program divisions of the hospital organization shown below. For the first half of the current fiscal year (1975-76) the average daily attendance of this inpatient population based on daily midnight bed count was:

PROGRAM DIVISION	REQUIREMENTS FOR ADMISSION	ADA
Alcoholic Treatment Center	Severe drinking problem.	56
Drug Treatment Center	Severe drug abuse	36
Children and Adolescent Treatment Center	Severe psychiatric illness through age 16	67
Geriatric Treatment Center	Severe psychiatric illness for patients over age 60	238
General Adult Psychiatric Services	Acute and severe psychiatric illness for patients age 17-64	121
Division of Forensic Psychiatry	Criminal court evaluations and criminally insane	284
General Hospital Services	Medical-surgical problems	72
	CSH Total Inpatient Population:	874

The first five program divisions currently serve forty-seven counties of the southern and western portions of the state. The Division of Forensic Psychiatry and the General Hospital Services serve all sixty-three counties of the state. The General Hospital also serves non-psychiatric residents of the other state institutions.

4. Efforts to Avoid Chronicity

The philosophy of the hospital has long been focused on intensive care, alternatives to hospitalization and methods to prevent or

eliminate institutional dependency and apathy in treatment programs. Discharge planning begins at the time of admission and becomes more specific with each review of the treatment plan. There are no wards for chronic patients (except the neurologically disabled in the General Hospital) and the philosophy of "maximum mixture" of all types of clients is followed in assigning clients to treatment units.

Discharge planning gives priority to the principle of trial release at risk of failure over that of waiting for certainty of success before discharge. Frequent use is made of passes and home visits to get the client reaccustomed to his/her community environment.

Other methods to prevent institutionalization include confrontation techniques to stimulate motivation, psychodrama (rehearsal for community life by acting-out of community life situations), training in adaptive daily living skills and alternative life styles, assertiveness training, behavior modification for inappropriate or other behavior unacceptable in the community, maintenance on the lowest level of psychotropic medication necessary to control symptomatology, job and living placement counseling and the social and recreational stimulation described below.

5. Provision of Social and Recreational Stimulation

Activities providing this type of stimulation are of two basic types: direct therapeutic intervention for a specific behavior change or treatment objective and diversional activities for the maintenance or stimulation of social and physical assets and interests. The primary planners and providers of these activities are the recreational and occupational therapists, plus a variety of other disciplines involved

in conducting special group therapy or ward community meetings. The participation of ward nursing personnel in many activities is quite extensive and absolutely essential to their operation and effectiveness.

Activities are conducted on the ward or in other division facilities, in the hospital's central gymnasium or off the grounds. There are dyadic, small group and large group events involving both staff-client and client interaction of both a formal and informal nature. All divisions, except Forensic, provide co-educational living.

The central gymnasium provides facilities for an extensive client library, swimming pool and other forms of recreation, and the Department of Religious Therapies provides religious activities and counseling to all clients of CSH.

6. Evolving Role of Colorado State Hospital in the Mental Health Service Delivery System

The CSH campus that once housed over 6,000 clients has evolved since 1961 into a Human Services-Educational complex with CSH serving as the nucleus of the complex and providing the supporting services required. In this complex are the State Home and Training School (Resource Center for the Developmentally Disabled) at Pueblo, the emergency, inpatient and partial hospitalization program for the Spanish Peaks Mental Health Center, an office of the Colorado Attorney General's Office, the Division of Youth Services' Pueblo office, the Division of Wildlife's Pueblo office, the Adult Parole Pueblo office, the Department of Social Services Medical Health Unit, the State Department of Personnel Pueblo office, office of Region VII Health Planner and the Family Practice Residency Training Program. It is also projected

that the Colorado State Hospital-Human Services Complex will house a correctional work release unit and the Division of Youth Services Pueblo Detention Center. It is planned that in addition to providing facilities for the above named programs, the CSH will continue to be actively engaged in participating in training a wide range of mental health professionals to include career psychiatric residents from the University of Colorado Medical Center, psychiatric technicians from the University of Southern Colorado, social work students from the University of Denver and Colorado State University, and occupational therapists plus a variety of other mental health workers.

It is planned that CSH will continue to provide emergency and adult inpatient services for the metropolitan Pueblo community. Adult partial care services will be phased into the Spanish Peaks Mental Health Center.

Maximum use will be made of local general hospitals and alternatives to hospitalization by Western Slope centers and clinics and other centers and clinics in the CSH service area which are located a considerable distance from CSH. However, the impact on CSH will be gradual because of the time necessary to develop alternate treatment facilities and affiliation agreements with local hospitals.

It is also planned that CSH will provide very limited outpatient services. Such services will be provided in concurrence with the appropriate mental health center or clinic and only for cogent reasons.

CSH will phase down its alcohol and drug abuse treatment programs to a level to be determined by the Divisions of Alcohol and Drug Abuse

and Mental Health. As with FLMHC, hospital services will not be phased down until adequate services and facilities are available in the community.

Every effort will be made to treat adolescents and children in their own community. However, because of the inordinately high cost of operating an inpatient facility and the need for highly trained specialists to operate such a program, it is planned that CSH will continue to provide centralized inpatient services to children and adolescents from its service area.

CSH will continue to operate the General Hospital and its Forensic and Geriatric treatment programs.

It is planned that CSH will develop a number of pilot programs such as a special psychiatric treatment program for Chicano clients. Implementation of such pilot programs will of course be contingent upon the availability of special funding.

Expanded educational activities for CSH will include developing the capacity for serving as a regional continuing education center for the southern Colorado region of the state to provide accredited continuing education programs for health service professionals. Consideration will be given to designing and submitting to national and state continuing education accrediting authorities a written proposal for designating CSH as an official center for continuing education in the fields of psychiatry, psychology, social work, nursing and general and special medicine.

E. FOLLOW-UP 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 follow-up care which will prevent or minimize the need for further inpatient care and promote the best possible social adjustment. Responsibility for follow-up care generally rests with the catchment area mental health center or clinic. However, in specific cases, follow-up care may be provided by CSH or FLMHC if the responsible center/clinic and the hospital agree that such is in the best interest of the client.

1. Pre-Discharge Planning Procedure

   a. Initial planning for follow-up care takes place at the time of admission to inpatient care or during the pre-admission process. Community mental health center and clinic staff and/or hospital staff responsible for evaluation will assess the client's potential for independent living after inpatient treatment. Included in this early assessment is the person's social system strengths and weaknesses, the seriousness of the person's impairment in areas where normalized living is affected and the community support system available.

   b. During treatment the client is involved to the maximum extent possible in plans for follow-up care after release.

   c. As discharge approaches, both staffs assess the person's need for follow-up care.

(1) Clients who can be discharged without need for any follow-up care exit from the mental health system and no responsibility for follow-up is assigned.

(2) For clients who can be discharged from inpatient care but need a brief transitional follow-up to be certain treatment has been completed, short-term follow-up care for a period of up to 60 days may be provided by hospital staff with the concurrence of the appropriate mental health center or clinic. At the conclusion of the transitional follow-up, the client may exit the system, be followed-up by the responsible center or clinic, or be returned to inpatient care if such is indicated.

(3) Clients being discharged from inpatient care who need ongoing supportive care are the responsibility of the local community mental health center or the referring private sector source if the client's wish is to be followed by a private therapist. Disposition planning involves the hospital and community referral sources and the client so transition from inpatient care to other care is as smooth as possible.

(4) Unless specific and documented arrangements are made for CSH or FLMHC to follow-up a client discharged from inpatient care who requires long-term support and maintenance, catchment area centers and clinics are responsible to help the client avoid the return to inpatient care. This will be accomplished by ensuring that the client is followed in a resocialization group and/or seen periodically

on an outpatient basis or for medication check. Progress notes will be recorded after each contact or at least monthly.

(5) Maximum use is to be made of alternate treatment facilities in each catchment area, including nursing homes, intermediate care facilities, boarding homes, halfway houses, family care homes and foster homes, as well as providing services to persons in their own homes. The client will be placed in the facility which provides that level of care which meets the individual's clinical needs. Every effort will be made to move persons placed in more intensive settings, such as nursing homes, to a less restrictive placement as soon as his/her condition permits. No placements will be made without the concurrence of the client and the catchment area center or clinic. Centers and clinics may not refuse aftercare services to clients who need and will accept such care.

(6) Coordination of placement activities with the social services department is essential. This will help ensure proper use of available resources and payment for services provided clients who are eligible for Social Security and other state and federal benefits.

(7) All facilities used as alternatives to inpatient care must be properly licensed if licensure is required, and must comply with any existing standards for the care of mentally ill clients in such facilities.

d. Upon discharge from inpatient care, each person who has agreed to follow-up care will be fully advised as to who has responsibility for follow-up care (center/clinic, hospital, private practitioner, etc.). When transfer of responsibility for inpatient care occurs, the person is discharged from the hospital rolls.

e. All decisions concerning aftercare will be documented in each client's chart. These charts will be randomly audited to insure proper documentation and follow-up.

f. Lists of clients transferred or discharged from CSH and FLMHC inpatient programs to aftercare or follow-up will be maintained by both hospitals. These lists will include the hospital number, the date of transfer or discharge, the client's address at the time of transfer or discharge and the name of the center/clinic.

g. Readmission to inpatient care of clients being provided follow-up care by community mental health centers/clinics will be monitored by the Division of Mental Health.

2. Responsible Center/Clinic in Each Catchment Area

The responsible community mental health center or clinic in each catchment area is designated in Chapter VI, Subsection C.

3. Policies for Discharge from State Hospitals

The quality assurance programs of both state hospitals serve as excellent tools for identifying inpatients who should be considered for discharge to the community or transfer to a less intensive level of treatment.

The goal for every client is eventual exit from the mental health system. Discharge from a state hospital occurs when the client has obtained maximum benefit from hospital programs or appropriate and adequate care is available in a less restrictive setting or no further care is indicated. Thus, discharge may take the form of total exit from the mental health system or transfer of responsibility from a state hospital to a community mental health center, clinic or other appropriate mental health resource.

The policy of the Division of Mental Health is to treat clients in the least restrictive setting. No client will be retained in inpatient care who can receive appropriate and adequate care in another setting. The preferred setting is the individual's own community. Continuing assessments will be made of the inpatient rolls at both hospitals to assure the immediate discharge or transfer from inpatient care of any client who does not specifically require inpatient care.

Information on a client will be shared only if the client has signed an appropriate release of information. The only exception will be when there is a court order permitting release of information or when a state statute specifically provides for the sharing of information on certain clients.

4. Methods for Assuring Availability of Follow-Up Care

The Division of Mental Health is responsible for the overall planning for a range of follow-up services on a local, regional and statewide basis. The Division assumes responsibility for requesting adequate funding for necessary follow-up care facilities. The

Division of Mental Health will ensure adequate monitoring of hospital and center/clinic follow-up programs for quality and cost effectiveness.

Community mental health centers and clinics have the primary responsibility for developing and providing adequate basic follow-up services for clients in their catchment area. They will be expected to work in coordination and cooperation with the state hospitals. Centers and clinics will work with social services and other community agencies to develop a range of living arrangements appropriate for clients and ex-clients. They will also work toward developing healthy community attitudes toward clients and ex-clients. It will be the responsibility of community mental health centers and clinics to inform the Division of Mental Health of gaps in follow-up service resulting in increased usage of other programs.

The state hospitals are responsible for informing the Division of gaps in follow-up service. The hospitals' follow-up and aftercare responsibilities will be phased down as mental health centers and clinics increase their capacity to exercise their primary responsibility in this area. CSH and FLMHC will cooperate fully with centers and clinics in the follow-up planning process.

F. WORKFORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Workforce (Manpower/Womanpower)

The following is a summary of current personnel in hospitals, centers and clinics in the state public mental health system.

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DISCIPLINE	FULL TIME STAFF	PART TIME STAFF
M.D., Psychiatrist	51	64
M.D., Non-Psychiatrist	34	87
Osteopathic Physician	0	0
Nurse, M.S.	28	2
Nurse, R.N. & B.S.	132	8
Nurse, R.N.	150	1
Nurse, Practical	23	3
Mental Health Worker, A.A.	211	5
Mental Health Work	83	6
Social Worker, D.S.W.	1	2
Social Worker, Masters	234	36
Social Worker, Bachelor	56	7
Psychologist, Ph.D.	107	23
Psychologist, Masters	69	11
Psychologist, Bachelor	10	3
Other Doctorate level	11	2
Other Master level	64	7
Other Bachelor level	129	25
Other A.A. level	8	0
Other	1574	162
	2984	454

Included in the "other" category are:

Information Specialists
Librarians
Teachers
Administrative Officers
Accountants
Personnel Officers
Purchasing Agents
Clerical Entry through Secretary II
Storekeepers
Supply Officers
PBX Operators
Reproduction Equipment Operators
Physical Plant Managers
Labor & Grounds Maintenance
Carpenters
Electricians
Painters
Typefitters
Plumbers
Plasterers
Sheet Metal Workers
General Plant Mechanics
Machinists
Automotive Servicemen & Mechanics
Welders
Refrigeration Mechanics
Stationary Firemen & Engineers
Truck Drivers
Safety Inspectors
Public Safety Guards & Officers
Food Service Workers, Cooks, Bakers & Meatcutters
Dietitians
Laundry Workers & Supervisors
Custodial Workers & Supervisors
Barbers
Beauticians

2. Projection of Personnel Needs

The current staffing will be adequate for the initial phase of the plan. As centers and clinics take on a more comprehensive role, some changes in function of the current personnel may be required. The Division of Mental Health will take the initiative to encourage educational facilities to provide the clinical skills required. It

appears that the mental health professionals will be in adequate supply except for psychiatrists and possibly for nurses.

The Division of Mental Health is also involved in a statewide effort to upgrade the skill level of mental health manpower through the Division's staff development program. This effort includes an application for federal funding for training personnel in the provision of the additional services mandated by PL 94-63.

3. Development and Maintenance of an Adequate Supply of Mental Health Personnel

The development and maintenance of an adequate supply of mental health personnel requires the joint efforts of the colleges and universities in providing the basic professional education (preservice training) and of the service delivery system in providing the postgraduate or continuing education of mental health professionals and paraprofessionals. The two state hospitals and several centers and clinics actively work to strengthen the curriculum in local colleges and universities for mental health workers and provide incentives for persons with less than an AA degree to pursue further education. The goals of continuing education are both individual and organizational: to maintain and update the skills of the individual clinician; and to provide a mechanism for accomplishing planned changes in service delivery. The ongoing professional development of employees is essential to retain experienced personnel and to ensure the delivery of an adequate quantity and quality of services. Therefore, resources for the continuing education of mental health professionals and paraprofessionals must be built into the service delivery system to ensure

that the necessary staff skills are available to effectively implement program goals and objectives.

The term "continuing education" is used to include all those educational activities beyond the basic discipline training program whether provided by academic institutions, professional societies or by service agencies themselves. However, it is limited to the ongoing education of mental health professionals and paraprofessionals. Thus, the concept of continuing education is quite discrete from "consultation and education." The latter term is used to describe a range of activities directed towards the mental health education of lay citizens or non-mental health professionals such as teachers, welfare workers, clergy or law enforcement personnel.

Within the context of the service agency, continuing education is often used synonymously with the term "staff development." It would include a diverse range of activities such as: formally organized inservice classes, seminars or workshops; case conferences and clinical consultations which are primarily oriented towards an educational goal; sending staff to attend externally sponsored educational offerings; and development of organizational policies, structures and resources in support of the ongoing professional development of agency personnel.

The appropriate role of the Division of Mental Health in continuing education is to provide initiative and leadership in certain functions. These would include identifying statewide training needs and priorities, establishing and administering enabling mechanisms and developing the resources needed.

The role of the individual agencies would include developing and providing the staff development services required by their staff and ensuring that these services are congruent with the goals and objectives of the agency. These roles of the Division and the individual agency do not diminish the responsibility of each mental health professional to maintain his/her knowledge and skill in keeping with the standards of his/her respective profession.

Among the agencies of Colorado's mental health system, there is great variability in the priority and support given to continuing education. Some agencies have well developed programs; others do not. Centers and clinics in rural areas are often handicapped by the lack of availability of resources. Larger centers are handicapped by decentralized teams and geographically dispersed satellites. A great deal of effort on the part of the Division and each agency is required to develop and maintain the skills required of the mental health personnel comprising the state mental health system.

4. Procedure for Protecting Displaced Employees Rights

The primary protection for state hospital employees who might be affected by a reduction in the workload at the state hospitals is the Civil Service System. The rules of the Civil Service System provide for "bumping" rights, lateral transfers and preference in filling personnel vacancies which develop in state agencies. There are some thirty thousand state employees. With a turnover rate of approximately ten percent, up to three thousand existing positions plus newly funded positions become available during each year. "Bumping" rights can be exercised only within the department in which

an individual is employed. The Department of Institutions, of which the Division of Mental Health is a component, employs almost five thousand persons across the state. Thus, displaced state hospital personnel would have a number of options available to them within the state system. Important considerations are the location of a vacancy and an employee's willingness to relocate. In view of the concentration of state agencies in the Denver and Pueblo areas, the importance of the relocation factor is diminished.

The twenty-four mental health centers and clinics employ some twelve hundred persons. All of these agencies are private, non-profit corporations, except two which are county agencies. Each has its own personnel system, none of which are related in any way to the State Civil Service System. Many state hospital employees have acquired valuable skills in the treatment of the chronically ill and other difficult to treat clients. These skills can be put to good use in community agencies as they assume increasing responsibility for more seriously disabled clients. Centers and clinics will continue to send announcements of vacancies to the Division of Mental Health Personnel Officer, who is forwarding copies for posting in the state hospitals. A major concern of state hospital employees who wish to work in a center or clinic is the non-portability of retirement and other benefits from the state system to private or county agencies. While legislative relief is possible, it is not probable because of the myraid legal, funding and other problems involved. A proposed partial resolution would be placing selected state hospital employees

on "detached service" at a center/clinic. The state employees would remain on the state hospital payroll, and the center/clinic would reimburse the state hospital for the employee's salary and other benefits. The employees would have to be acceptable to the center/clinic concerned and would be under the administrative control of the center/clinic director. This proposal is fraught with many problems, such as differences in salaries, fringe benefits, classification, etc., between the state system and individual centers/clinics. However, it is one avenue that is being explored.

Another important need which will be dealt with as the need arises is training of displaced employees for new jobs in centers/clinics and the state hospitals. The plan is to accomplish this through such means as on-the-job training, regular college or university course work and/or special formal training sessions conducted as a part of the Division's continuing education program or arranged through local colleges and universities.

The fact that implementation of the Plan will take place over a five year period will allow some of any possible personnel displacement to be handled via normal attrition.

There will be continuous monitoring of the impact of the Plan on state hospital personnel. Specific actions will be initiated as required to prevent or hold personnel displacements to the lowest possible level.

V. COORDINATION OF PLANNING

A. INTERDEPARTMENTAL COMPREHENSIVE PLANNING

1. Human Services Policy Council

In 1975, the Governor of Colorado established the Human Services Cabinet Council (now called the Human Services Policy Council) to develop coordinated planning and implementation of human service programs in the state. Seven departments of state government participate in the Council, through representation by the Executive Director of each department. Departments involved are: Education, Health, Institutions (which includes the Division of Mental Health), Labor and Employment, Local Affairs, Social Services and State Planning and Budgeting. Also participating are representatives of the Governor's office, including the Governor's Office of Human Resources.

The Human Services Policy Council develops policies which will relate to areas of service throughout the executive branch of state government. Following recommendations to the Governor and approval of the policy statement by the Governor, the Council is responsible for implementation of the policies including coordinated planning and budgeting by the various departments. Specific agreements are developed between departments, outlining areas of program collaboration. The first human services policy priority has been services for the aging, with the goal of assisting older persons in maintaining themselves in independent living situations. Agreements between departments have specified mechanisms for coordinated planning and budgeting, as well as integrated service delivery, to implement the goal.

Other policy areas will be developed, leading to increased collaboration between programs which are provided by separate departments, and reducing barriers to comprehensive, integrated service delivery. Information about the policies and collaboration agreements must be disseminated to agencies and sub-units within the departments.

2. Office of State Planning and Budgeting

The Office of State Planning and Budgeting, through the Division of Planning, is responsible for coordination of planning in all departments of state government.

The statute establishing the Division of Planning (24-37-202, CRS 1973 as amended) specifies responsibilities for state-level review and coordination of planning:

a. coordinate the preparation and maintenance of long-range master plans which recommend executive and legislative actions for achieving desired state objectives and which include recommended methods for evaluation;

b. stimulate, encourage, and assist state agencies to engage in long-range and short-range planning in their respective areas of responsibility;

c. review and coordinate the planning efforts of state agencies, including the relationship of such efforts with federal and local government programs.

The Division is also the clearinghouse for state agency applications for federal grants subject to review under provisions of the Bureau of the Budget A-95 regulations. Within the Office of State Planning and Budgeting, the Division reviews the Executive Budget to

assure that budget requests match the established plans of state departments and agencies.

Coordination by the Division of State Planning, working with planning staffs in other state departments, divisions and agencies, will increase the coordination of services, eliminate unnecessary duplication, and develop additional programs where needs are now not met.

3. Health Planning

The Colorado Department of Health, containing the Division of Comprehensive Health Planning, was designated as the state health planning agency by the Governor of Colorado, in accordance with PL 89-749 (the comprehensive health planning legislation), in March 1973. Up to that time the Office of Comprehensive Health Planning Had been located within the Governor's Office and the Department of Local Affairs. The Division was transferred at that time to the Department of Health to continue as the unit responsible for health planning. The Colorado Health Planning Council, appointed by the Governor, is the policy-making body for the Division.

In 1975, three health service areas were established in Colorado, as provided in the National Health Planning and Resources Development Act of 1974 (PL 93-641). A non-profit corporation has been created in each of the areas, and all three have applied for and received conditional designation under that Act as health systems agencies. A Statewide Health Coordinating Council is yet to be selected. The Council, a citizens group with a consumer majority, will have sixty percent of the membership selected by the Governor from nominees of the health systems agencies; the other forty percent will be designated at-large

by the Governor. To date, a board has been chosen by each of the Health Systems Agencies. The Statewide Health Coordinating Council will be appointed by January 1977. The State Health Planning and Development Agency, an agency of the state government, has not yet been designated by the Governor. Until the Council and the Agency are selected, the Colorado Health Planning Council and the Division of Comprehensive Health Planning continue to perform the state-level planning and coordinating functions.

The Division of Comprehensive Health Planning is developing a plan framework for health services, both public and private, on a statewide basis and coordinates and provides guidelines for planning by areawide comprehensive health planning councils, which are operational in the thirteen Planning and Management Regions of the state. When the structure of PL 93-641 is implemented, the thirteen areawide councils will be replaced with three Health Systems Agencies, although sub-area councils will, in many regions, continue some of the planning and coordinating roles as advisory groups of the Health Systems Agencies. The various mental health agencies in Colorado have been involved at the local level to varying degrees with the areawide health planning councils. The latter, in many regions, have had a role in the A-95 review process regarding mental health proposals.

At the state level, the Department of Institutions is represented on the Colorado Health Planning Council, and for the past two years the representative was the director of the Division of Mental Health. Mental Health volunteers have also been active in health planning, and the current

chairman of the Council was formerly the president of the Mental Health Association of Colorado and is a vice-president of the National Association for Mental Health.

Of the three areawide health planning councils in the state which currently have specific health plans in adopted form, two have directly addressed mental health, and the third has included it in its outline. In addition, the outline of the Colorado Health Systems Plan Framework includes mental health services. A staff person from the Division of Comprehensive Health Planning is participating in the development of this plan (the Five Year Mental Health Plan).

The National Health Planning and Resources Development Act (PL 93-641), and particularly the regulations resulting from it, calls for the effective planning and development of both physical and mental health services. Consequently, the functions of the various entities created by this legislation will have impact on the planning and delivery of services by the various mental health agencies. Each health systems agency (HSA) will have specific responsibilities, including the following:

a. establish a health systems plan and annual implementation plan for the area;

b. review and approve or disapprove grant requests for designated federal funds (including funds appropriated under the Community Mental Health Centers Act and the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act);

c. implement plans through developmental grants to community agencies;

d. recommend health facilities projects to the state for funding;

e. periodically review and comment on the appropriateness of all institutional health services in the area; and

f. coordinate its activities with other planning or administrative agencies such as Professional Standards Review Organizations.

Some of these functions, particularly (b) and (c), will not be performed during the initial period (up to one year) of a given health systems agency's designation.

The Statewide Health Coordinating Council will review and coordinate planning activities of the HSA's, prepare and approve a state health plan based on the health systems plans of the HSA's, and advise the State Health Planning and Development Agency in its work of statewide health planning and implementation of the state health plan.

Mental health agencies have been involved to some extent, through representation by staff and board members, on planning committees and by election to board membership of the health systems agencies.

Implementation of the health planning and resources development program should accomplish the following:

a. enhance the development of comprehensive health service systems, including mental health, in all areas of the state;

b. increase and broaden community involvement in mental health, particularly of those providers and consumers not in the mental health field;

c. facilitate closer coordination between the public and private sectors of the mental health delivery system;

d. improve the availability of services in rural and other underserved areas; and

e. limit unnecessary duplication of services.

In order to achieve these outcomes, mental health center and clinic board members, other volunteers, and mental health professionals must involve themselves to an even greater degree in the health planning process. This can be accomplished in part by participation on the boards, committees, and task forces of the health systems agencies and on the Statewide Health Coordinating Council and its task forces. The HSA's and the Coordinating Council, in turn, must facilitate this involvement.

4. Health Facilities Advisory Council

The Department of Health is designated by state statutes as the sole agency for carrying out the purposes of the Community Mental Health Centers Construction Act of 1963 and any amendments thereto. The State Health Facilities Advisory Council (HFAC) is a statutory body appointed by the Governor to advise the Department of Health on matters involving construction of mental health and other health care facilities. Four of the 18 members of HFAC are mental health representatives: two consumers, one public service provider, and one private service provider.

There have been some communications problems among the applicants for approval and funding of projects because of the many changes which

take place during the grant review process. These applicants include HFAC, DMH, and the Regional Department of Health, Education, and Welfare Office (DHEW). This problem will be minimized by ensuring that all significant communications are documented, and all concerned agencies receive a copy of each communication.

B. INTERDEPARTMENTAL PROGRAM PLANNING

1. Division of Alcohol and Drug Abuse

The state alcohol and drug abuse authority, by statute, is the Division of Alcohol and Drug Abuse (DADA), which is a component of the Colorado Department of Health. The Department of Health, through DADA, is responsible for formulation of an annual comprehensive state plan for alcohol and drug abuse programs, supervision of the administration of the plan, and coordination of state and federal funds for alcohol and drug abuse services. By statute, DADA is the state alcohol and drug abuse authority; therefore, the DADA alcohol and drug abuse plan is the official substance abuse plan for the state. The state general fund appropriation to DADA in fiscal year 1975-76 was $1,526,910. The Division also allocated or approved the allocation of some $4,000,000 in federal funds. DADA does not operate programs directly, but purchases services from approved agencies.

Mental health agencies, operated and/or funded through the Division of Mental Health (DMH), are actively involved with alcohol and drug abuse services. Most alcohol and drug abuse services are funded through the

Division of Alcohol and Drug Abuse, utilizing both federal and state funds. In fiscal year 1975-76, DADA had 39 contracts with mental health centers/clinics (including the Drug Treatment Center at Colorado State Hospital) to provide alcohol and drug services. During the same year, state general funds in the amount of approximately 1.4 million dollars were appropriated directly to Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) for the treatment of alcoholism, and 0.5 million dollars to CSH for drug abuse services. Additionally, a substantial percentage of the approximately 9.5 million dollars in state general funds appropriated to mental health centers and clinics in FY 75-76 was used for the treatment of center and clinic clients whose diagnosis included alcohol and/or drug abuse. Finally, of the centers' and clinics' projected income of 12.4 million dollars for the year from non-state sources (federal and local governments, fees, third-party payments) some is being used to purchase alcohol and drug abuse services.

Some achievements in coordination between DADA and DMH in the funding and operation of services include: DADA contracts with DMH-related agencies; cooperation and collaboration in the preparation of budget documents to prevent duplicate requests; beginning work on a common workload data reporting system. During the coming year, as reflected in the Objectives in Chapter III, there will be a concentrated interdepartmental planning project, involving DADA and DMH, to develop procedures for coordinated planning, funding, and delivery of alcohol and drug abuse services in relation to the mental health services delivery system.

Issues that will be addressed by the two Divisions and the two Departments include:

a. a common data base and common terminology;

b. agreement as to types, levels and intensities of services to be provided;

c. interdepartmental program budgets and funding procedures;

d. provision of appropriate alcohol and drug abuse services to clients of the mental health service system, and appropriate psychiatric services to clients of the alcohol and drug abuse service system;

e. definition of the role of the mental health services delivery system in the delivery of alcohol and drug abuse services;

f. agreement on training needs and standards for all persons who treat substance abusers;

g. development of plans for research into the etiology of alcoholism and effective treatment strategies;

h. active participation of mental health agencies, including centers and clinics, in the development and revision of alcohol and drug abuse plans, and active involvement of DADA in the preparation and updating of the state mental health plan;

i. development of plans for diminishing state hospital-based alcohol and drug abuse services, and a concurrent increase

in the availability of alcohol and drug abuse services in local communities;

j. development of a methodology for determining the outcome and impact of alcohol and drug abuse services.

2. Department of Social Services

The Department of Social Services (DSS) is responsible for the administration of a host of social and medical programs. DMH and DSS have many common interests and concerns. However, the primary interface between these two human service agencies involves reimbursement for mental health and rehabilitation services to emotionally disabled children, adolescents, adults, and aged persons.

Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) receive Title XVIII (Medicare), Title XIX (Medicaid) and vocational rehabilitation funds from DSS. Mental health centers and clinics are recipients of Medicare and Medicaid funds for services to eligible clients. The vocational rehabilitation programs in the hospitals and several centers have experienced a number of major changes and periods of uncertainty because of unpredictable and severe reductions in vocational rehabilitation funding. Mental health centers and clinics have found that as little as 40 percent of Medicaid claims have been reimbursed, and they have received differing interpretations as to what charges are payable. A major problem has been the requirement that a physician must see each client for whom a Medicaid claim is submitted. This has worked a particular hardship on rural programs which have large percentages of Medicaid eligible clients and limited

physician coverage, and has dramatically reduced the potential income to all centers and clinics from this source.

The state receives some 29 million dollars in Title XX funds. However, in contrast to many other states, none of these funds are available for the purchase of mental health services. Therefore, in Colorado the mental health agencies cannot assume responsibility for developing or providing services funded by Title XX. The responsibility lies instead with county social service departments.

The coordination of planning between DSS and DMH has improved markedly during the past year. With the assistance of the executive directors of DSS and the Department of Institutions, a plan was formulated to transfer state general funds from mental health centers and clinics to DSS. These dollars were to be matched by Medicaid funds on an approximately 55 percent (federal) to 45 percent (state) basis. When it was determined that the transfer could not be accomplished without an amendment of a state statute, DSS's legal counsel drafted an amendment which was included on the legislative calendar through a successful attempt by the director of DSS. The proposed amendment was postponed indefinitely because of some uncertainty as to the possible effects of the amendment.

DSS supported the efforts of the Colorado Association of Community Mental Health Centers and Clinics and DMH to develop a new Medicaid reimbursement formula. Payments under the formula have been delayed pending completion of negotiations with the Professional Standards Review Organization, the Colorado Foundation for Medical Care.

It is anticipated that coordinated planning between DSS and DMH will continue. The expected outcomes are: increased payments for mental health services to persons eligible for medical assistance under Medicare and Medicaid; the successful negotiation of contracts between DSS and community mental health centers and clinics; expanded vocational rehabilitation services for mental health clients; and coordinated provision of services for the elderly.

3. Department of Education

Coordination of planning between the Department of Education and mental health services of the Department of Institutions is included in the policy-development activities of the Human Services Policy Council. Additionally, a representative of the Division of Mental Health has provided input to plans of the Division of Special Education of the Department of Education.

At present there are some areas of program coordination between mental health agencies and the Department of Education. Under provisions of the state Handicapped Children's Educational Act, school districts and boards of cooperative services may contract with mental health centers or clinics to purchase diagnostic evaluation services for handicapped children, teacher and parent counseling or consultation, and inservice education for school staff and volunteers. Therapy services for children are not eligible for reimbursement to mental health agencies. In 1975, sixteen centers and clinics in rural areas of the state had contracted to provide the evaluation, consultation and training services; in urban areas, these services are provided

directly by school personnel. Limited amounts of funds from the Elementary and Secondary Education Act (federal), administered through the Department of Education have been available to supplement the school programs at the two state hospitals.

An area of planning being addressed by the Human Services Policy Council is services for the handicapped. Certainly education of the emotionally handicapped will be included in the development of policies and program goals. In addition, specific program coordination mechanisms should be developed:

a. a representative of the mental health system should be included in the membership of the State Special Education Advisory Committee;

b. a coordinating group, representing the Division of Mental Health and the Division of Special Education, should be created to plan and implement programs which will provide educational services to children excluded from public schools because of emotional handicaps;

c. changes in legislation should be sought to provide that local, state, and federal funds for education of the handicapped will be available, at an adequate level, to community or residential agencies which include educational services in treatment programs for the emotionally handicapped.

C. INTERDIVISIONAL PLANNING - DEPARTMENT OF INSTITUTIONS

Within the Department of Institutions are five Divisions: Corrections, Deaf and Blind, Developmental Disabilities, Mental Health, and Youth Services. All of the Divisions include residential agencies as well as community programs operated directly by the Divisions or through contracts with non-governmental agencies. Coordination of planning between Divisions is accomplished through regular meetings of the Division Directors and the Executive Director of the Department, through special planning meetings of the Directors, and through task forces to study program areas and make recommendations to the Executive Director.

For selected issue and policy areas, a committee of Division of Planning Directors develops coordinated planning between Divisions. The Interdivisional Placement Team, with a representative from each Division, reviews information about hard-to-place clients, designs a plan for treatment which may involve services to be provided by two or more Divisions, monitors the progress of treatment, and makes recommendations to the Executive Director about the need for new programs or revised structure of services to meet client needs. The Interdivisional Medical Services Committee surveys the adequacy of medical and related services in agencies of the Department of Institutions, including laboratory facilities and pharmacy services; recommendations are presented to the Executive Director to improve the quality and efficiency of these programs. In addition to these and other Department-wide task forces, representatives of Divisions are involved in program planning within

other Divisions; e.g., representatives of the School for the Deaf and Blind participated in planning the program of mental health services for the deaf at Fort Logan Mental Health Center, and representatives of the Division of Youth Services helped in the planning of new adolescent treatment units at Colorado State Hospital and Fort Logan Mental Health Center. Mental health centers in some areas have contracted to administer community corrections programs, and to provide services to agencies within other Divisions of the Department. The Chief of Diagnostic, Medical and Mental Health Services, in the Division of Corrections, manages and administrates provision of mental health services in that Division, and coordinates the relationship of mental health services of the Penitentiary and Reformatory with the Forensic Division and other units of Colorado State Hospital.

In many aspects, coordinated planning of services between Divisions of the Department of Institutions is being accomplished, but improved integration of services is still needed. Transfer of clients between Divisions, or provisions of services concurrently by agencies of two or more Divisions, should be implemented when required to meet the needs of clients. All mental health services to state agencies should be the responsibility of the Division of Mental Health, either through contracts under which agencies of the Division of Mental Health will provide services to other agencies, or by agreement with the Division of Mental Health that mental health services should be provided directly by those other agencies.

D. LOCAL GOVERNMENTAL PLANNING AND REGIONAL PLANNING

1. Department of Local Affairs - Division of Planning

The Division of Planning in the Department of Local Affairs has the statutory authority and responsibility for coordination of planning at the local level throughout the state.

The Division of Planning plays a dual role in assisting the planning process in Colorado. County and municipal governments engage in a continuous effort to plan and manage their futures, and the Planning Division provides them with technical and financial assistance. Other planning functions - including policy-making and regulation - are performed by various State government agencies, and the Division of Planning coordinates such activities.

The State A-95 Clearinghouse for non-State applications for federal funds is the Division of Planning in the Department of Local Affairs. A-95 is a federal program that requires all requests for federal grants to be reviewed by appropriate agencies at the local, regional, and state levels. The Division coordinates the project notification and review process with eight regional councils of governments, two area councils of governments, and one regional planning commission, each of which serves as a regional or area A-95 Clearinghouse. The Division, in addition, acts as the regional clearinghouse for three of the state's thirteen regions. (The State A-95 Clearinghouse for applications from State agencies is the Office of State Planning and Budgeting.)

Appropriate local, regional, and state review of all requests for federal funds, particularly as they relate to mental health, should

avoid unnecessary duplication of services and facilitate the implementation of the State Mental Health Plan, leading to a more effective and economical service delivery system. Increased input from the Division of Mental Health into the Division of Planning relative to the latter's role as technical advisor to local governments should result in greater involvement by those governments in local planning for mental health.

2. Regional Planning

The responsibility at the regional level for coordination between regional planning and mental health planning is shared by the respective regional council of governments and the region's mental health centers and clinics. Approximately 15 of the state's 24 centers and clinics have elected officials on their boards, which should provide for a degree of coordination. In some cases the board is selected in whole or in part by the county commissioners in the counties served by the center or clinic.

In addition to the involvement of elected officials, the staff and board members of mental health centers/clinics are involved in most communities in community planning for the total human services delivery system.

3. Municipal Planning

An example of mental health planning at the municipal level is the development of the Denver Mental Health Advisory Board, which has been sanctioned by the City and County of Denver and the seven mental health centers and clinics which provide services in Denver. The Division of Mental Health has been actively involved in this attempt to unify the mental health delivery system in Denver. Of particular importance is

the need to determine which services should be centralized to eliminate unnecessary duplication and achieve cost savings.

The overall objective of this effort is a unified mental health delivery system in Denver, involving one budget document that would provide for the distribution of mental health funds on the basis of the specific needs of the various sections of the city.

4. Four Corners Regional Development Commission

The Four Corners Commission is a federally-funded agency with the specific objective of economic development and job creation, particularly in rural areas, covering the states of Colorado, Utah, Arizona, and New Mexico. In Colorado it is administered by the Office of Rural Development, Department of Local Affairs. The Commission acts as a "funding agency of last resort" and supplements grants from other federal agencies and local funds. It apparently has not been involved in any mental health projects in the past but has participated in the funding of several hospitals and clinics. The possibilities of utilizing this resource for the development of mental health services should be explored further.

E. PUBLIC, VOLUNTARY, AND PRIVATE MENTAL HEALTH SERVICES

Much of the emphasis in this Plan is on the public mental health services - those agencies receiving federal, state, and local governmental funds for identified mental health treatment programs. Private and voluntary agencies provide a variety of mental health and counseling services in addition to the publicly funded programs. Referrals

are made between the voluntary and public agencies, and voluntary agencies often provide additional supportive services for public agency clients.

The Mental Health Association of Colorado is a citizens' organization which serves as an advocate for the mentally ill, promotes mental health through educational activities and support of legislation, and participates in the monitoring of public mental health services in the state. The Association also participates in studies of needs and programs, and was instrumental in organizing the planning process which developed the Denver Mental Health Plan. The Mile High United Way, in the Denver metropolitan area, and United Way agencies in other parts of the state, have a planning and coordinating function particularly with voluntary organizations providing mental health and counseling services. Associations of mental health professionals provide significant leadership in setting professional standards, encouraging or organizing continuing education, and participating in studies of plans, policies, and issues related to mental health programs.

Some cooperative relationships exist between the public, voluntary and private mental health services, but no comprehensive plan has been developed to coordinate planning and service delivery between the public programs and other agencies. The Division of Mental Health will organize a planning group, either as a task force related to the State Advisory Council or as a separate ad hoc study group. Membership will include representatives of the state-funded mental health system, voluntary agencies providing mental health services, private practitioners, professional associations, and the Mental Health Association. The

planning group will study issues and make recommendations to the Division of Mental Health.

Among the issues to be considered are:

a. identification of the range of mental health resources available through public, voluntary and private auspices, and criteria for admission to these services;

b. development of guidelines for relationships between public and voluntary or private services, including referral processes;

c. development of guidelines for purchase of mental health services from voluntary agencies, as appropriate, by catchment area centers and/or the Division of Mental Health.

VI. CATCHMENT AREA MENTAL HEALTH PROGRAM

A. DESCRIPTION OF CATCHMENT AREAS

A catchment area is defined as "a geographic area for which there is a designated responsibility for community mental health services." Colorado has designated 21 catchment areas. A specific community mental health center or clinic has been designated the catchment area center or clinic. The catchment area center/clinic has primary responsibility for providing a full range of community mental health services to its catchment area. These services may be provided directly by the center/clinic, or by an affiliate of the catchment area center/clinic.

The full range of community mental health services includes:

1. inpatient, outpatient, partial hospitalization, 24-hour emergency and consultation and education services;
2. other 24-hour care (i.e., residential alternatives to inpatient care);
3. services to children, adolescents, adults and the elderly;
4. appropriate vocational, activity, recreational and occupational therapies;
5. preadmission screening;
6. aftercare;
7. substance abuse services; (These services must be provided in accordance with the State Plan developed by the State Division of Alcohol and Drug Abuse, the statutory state alcohol and drug abuse authority.)

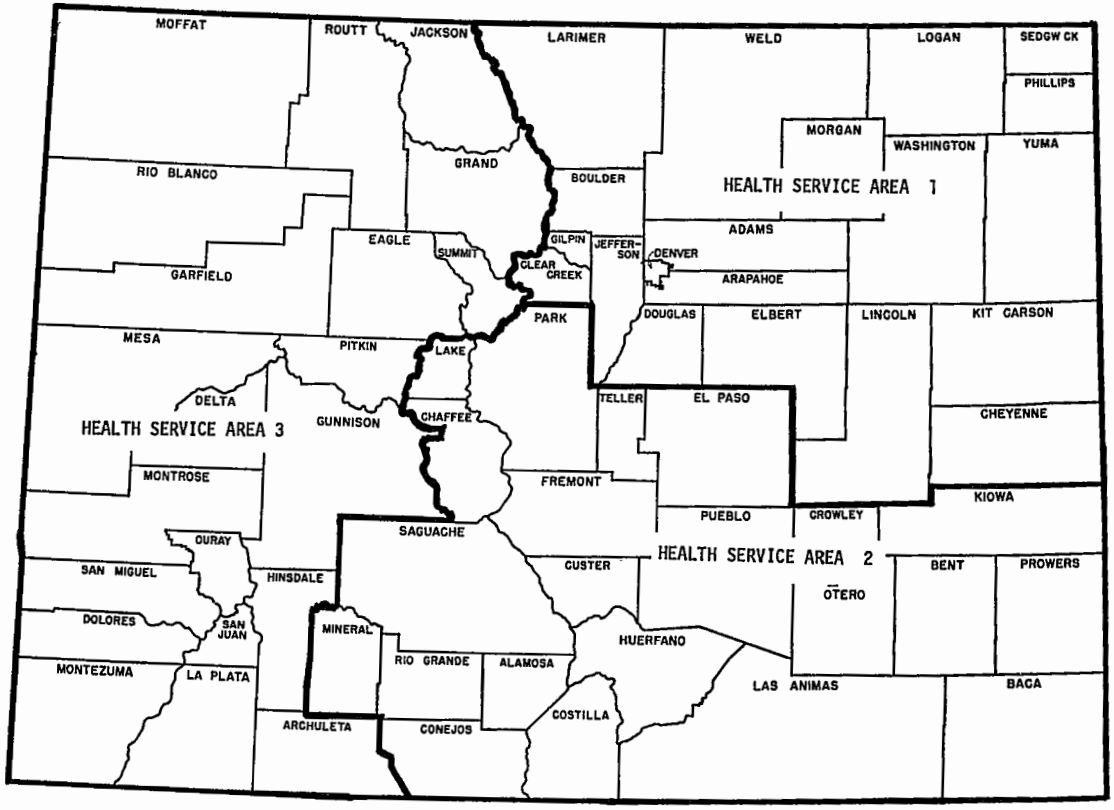
8. other services determined by local needs and the requirements of federal and other funding agencies.

Catchment area centers and clinics obviously vary in their ability to provide the above services. The capabilities of the smaller and underdeveloped agencies will be increased through such means as differential distribution of state funds, 314(d) and other special grants, assistance in applying for federal planning, initial operation and other grants, and continuing education programs for administrative and clinical staff.

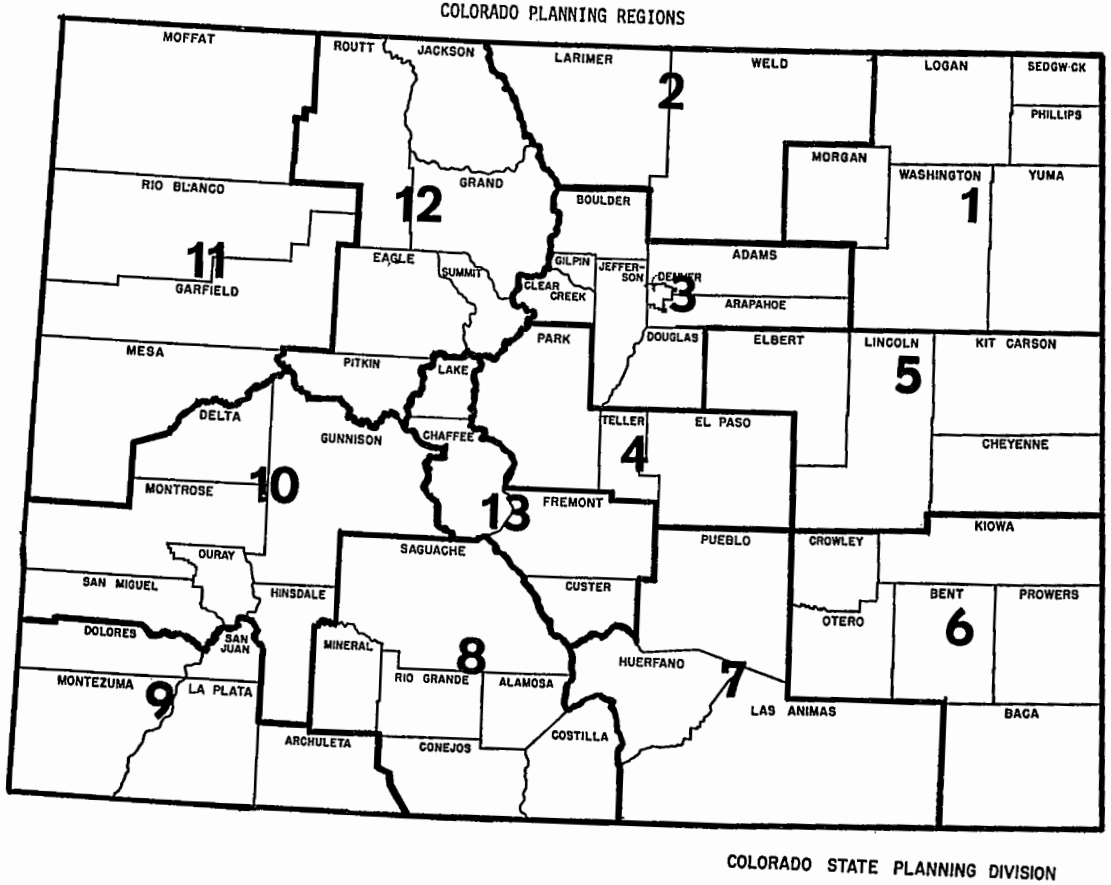
The geographical and health planning superstructure into which the catchment areas must fit is as follows:

1. Health Service Area: Colorado has three Health Service Areas (see map, page 3). A Health Systems Agency (HSA) has the overall responsibility for health planning in each Health Service Area.
2. Colorado Planning Regions: There are 13 State Planning Regions (see map, page 4). These regions were in existence prior to passage of Public Law 93-641 which requires the designation of Health Service Areas. The future role of the Planning Regions is not clear. They might continue to be viable entities for planning purposes because they provide more potential for local input than the HSA's, but are more manageable than 63 counties.
3. Counties: Colorado's 104,000 square miles and 2.7 million population are distributed over 63 counties (see maps, pages 3 and 4).

COLORADO HEALTH SERVICE AREAS



COLORADO HEALTH SERVICE AREAS


COLORADO PLANNING REGIONS
MOFFAT
ROUTT
JACKSON
LARIMER
WELD
LOGAN
SEDGWICK
PHILLIPS
MORGAN
WASHINGTON
YUMA
RIO BLANCO
GRAND
BOULDER
ADAMS
GILPIN
JEFFERSON
DENVER
ARAPAHOE
EAGLE
SUMMIT
CLEAR CREEK
GARFIELD
MESA
PITKIN
LAKE
PARK
DOUGLAS
ELBERT
LINCOLN
KIT CARSON
DELTA
GUNNISON
CHAFFEE
TELLER
EL PASO
CHEYENNE
MONTROSE
FREMONT
OURAY
SAGUACHE
PUEBLO
CROWLEY
KIOWA
SAN MIGUEL
HINSDALE
CUSTER
BENT
PROWERS
DOLORES
SAN JUAN
MINERAL
OTERO
HUERFANO
MONTEZUMA
LA PLATA
RIO GRANDE
ALAMOSA
LAS ANIMAS
BACA
ARCHULETA
CONEJOS
COSTILLA
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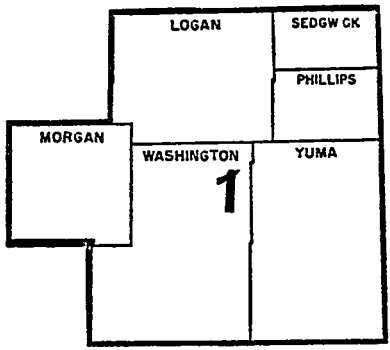
13
COLORADO STATE PLANNING DIVISION

4. Catchment Areas: Each of the 21 catchment areas is comprised of one or more counties, with the exception of Denver, which is divided into four catchment areas. No catchment area boundary crosses a county line. The chart on page 6 shows the relationships among Health Service Areas, Colorado Planning Regions, counties and catchment area mental health center/clinics.

Following is a brief description of each region, the services provided by the centers/clinics serving each region and program needs.

REGION I



Area: 9,228 square miles
Population: 66,918

Region I lies in the extreme northeastern corner of Colorado and encompasses Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. The area is bounded to the north by the Nebraska state line and on the east by the Nebraska and Kansas state lines. The

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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	Logan, Sedgwick, Phillips, Yuma, Washington, Morgan	Northeast Colorado Mental Health Clinic
1	2a	Weld	Weld MH Center, Inc.
1	2b	Larimer	Larimer County MH Center
1	3a	Adams	Adams County MH Center, Inc.
1	3b	Arapahoe, Douglas	Arapahoe MH Center, Inc.
1	3c	Boulder	MH Center of Boulder Co., Inc.
1	3d	Jefferson, Gilpin, Clear Creek	Jefferson County Mental Health Center, Inc.
1	3e	Southeast Denver	Bethesda Community MH Center
1	3f	Northwest Denver	Northwest Denver MH Center
1	3g	Northeast Denver	Park East MH Center
1	3h	Southwest Denver	SW Denver Comm. MH Services, Inc.
1	3i	Arapahoe, Adams	Aurora Mental Health Center
1	5	Elbert, Lincoln, Kit Carson, Cheyenne	East Central Colorado Mental Health Clinic, Inc.
2	4	Park, Teller, El Paso	Pikes Peak Family Counseling and Mental Health Center
2	6	Crowley, Kiowa, Prowers, Bent, Baca, Otero	Southeastern Colorado Family Guidance Center
2	7	Pueblo, Huerfano, Las Animas	Spanish Peaks Mental Health Center
2	8	Saguache, Mineral, Rio Grande, Alamosa, Costilla, Conejos	San Luis Valley Comprehensive Community MH Center
2	13	Lake, Chaffee, Fremont, Custer	West Central Mental Health Center, Inc.
3	9	Dolores, Montezuma, La Plata, San Juan, Archuleta	Southwest Colorado Mental Health Center, Inc.
3	10	Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale	Midwestern Colorado Mental Health Center, Inc.
3	11-12	Moffat, Routt, Jackson, Grand, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Summit	Colorado West Regional Mental Health Center, Inc.

southern extent of the region ends at the Lincoln and Kit Carson County lines and the western boundary is the Weld and Adams County lines.

1. Existing Services

The region is served by the Northeast Colorado Mental Health Clinic with headquarters in Sterling and branch offices in Fort Morgan and Yuma. Outreach services are provided to other communities in the region. County fiscal support of the clinic has been impressive; over the past several years, county funds have accounted for approximately one-third of the total budget of the clinic. The major service modalities of the clinic are outpatient evaluation and treatment services, juvenile diagnostic crisis shelter and counseling services, and consultation and education services to other community agencies. Emergency services are available 24 hours a day. A contract with the Division of Alcohol and Drug Abuse (Department of Health) supports client counseling, public education, and community organization efforts in alcoholism in the region.

2. Program Needs

With the above-average community support generated by the Northeast Clinic, the establishment of a wide range of mental health services will be possible within the next few years. The region has been transferred from the Colorado State Hospital service area to that of the Fort Logan Mental Health Center. This movement provides an excellent opportunity for the clinic to plan and implement several service elements, particularly alternative inpatient services for adults.

There are no hospitals within the catchment area providing separate units, beds or professional staff to treat serious emotionally or

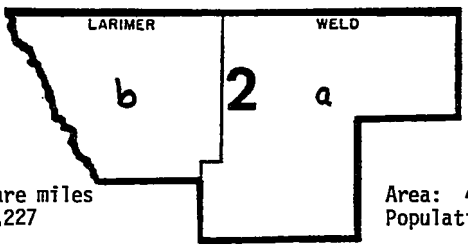
socially disturbed persons. The nine general hospitals will admit patients with a psychotic disorder or diagnosis, but they are not set up for treating such disturbances other than on an emergency basis. There is a need for specialized inpatient services and alternative treatment facilities in the catchment area.

A planning grant application has been submitted to the Department of Health, Education and Welfare to facilitate the establishment of comprehensive services to this catchment area and to the Region 5 catchment area. Under this proposal, Regions 1 and 5 would be combined into a single catchment area so that comprehensive services would be made available to both areas.

While the area of combined Regions 1 and 5 is very large, the population of these contiguous areas is quite sparse. Resources are scarce in both regions. The regions share many geographic, economic, political and social factors which increase the feasibility of amalgamation for the purposes of provision of comprehensive mental health services. Many of the Northeast Colorado Mental Health Clinic staff provide services on a part-time basis to Region 5.

As these plans are realized, catchment area changes and descriptions of services will be revised in the State Mental Health Plan.

REGION 2



Area: 2,614 square miles
Population: 124,227

Area: 4,004 square miles
Population: 116,407

Region 2a

Weld County, with a land area of 4,004 square miles, is one of the two counties in Planning Region 2. The Wyoming and Nebraska state lines form the northern boundary of Region 2a; Logan and Morgan Counties form the eastern boundary; the metropolitan area of Region 3 the southern boundary; and Boulder and Larimer Counties the western boundaries. This area encompasses the far northern area of the Colorado front range corridor. The Cache la Poudre and Big Thompson Rivers flow through the region and, coupled with efficient water resources management through the Colorado Big Thompson Project, provide this district with ample irrigation ability. The northern part of the county is a sparsely populated area dominated by the Pawnee National Grasslands. Major industries and employers include agribusiness, livestock, meat processing and education (University of Northern Colorado).

1. Existing Services

The county is served by the Weld Mental Health Center. The center received a federal staffing grant in November 1966, and the grant terminated in October 1974. Based upon the 1960 census data, the county was designated as a poverty area, and the center became eligible for poverty funding status. However, 1970 census data did not support continued poverty area designation of Weld County. No fiscal support of the program is received from the county; funding comes entirely from federal and state sources, fees, donations, and modest school contract funds and some support from the City of Greeley. The main service center and administrative offices recently moved into a new, well designed facility in Greeley.

There is a branch office in Fort Lupton, a community south of Greeley wherein a large proportion of the county's Chicano population resides. The center is attempting to increase its outreach efforts to Chicanos in the county and has made major strides, although additional resources need to be channeled into this effort.

Inpatient services are provided in the county hospital in Greeley, and the inpatient program is often filled to capacity. Adult day care services are provided through a separately organized facility called "Stepping Stone," which provides services for both chronic, longer term clients and clients in the inpatient unit. Emergency services are provided throughout the county.

A full range of services is available for the alcoholic and his family through the various center services and a specialized alcoholism outreach team. A halfway house provides an alternate living program for the alcoholic.

A specialized program for children and families provides emergency care, long term therapy and evaluation services. A drug program, "Lean-On," for teenagers and young adults is well utilized as a drop-in center in the community.

2. Program Needs

The Weld Center provides basic services for all categories of clients with the exception of geriatrics, forensic services and specialized inpatient services for children and adolescents. The possibility of some sharing of facilities and services by Weld and Larimer Counties will be explored.

Perhaps the highest priority for this region is the development of other 24-hour care services, such as a halfway house, to relieve

the growing pressure on the center's inpatient program.

There are no transitional care beds currently available for children or adolescents with chronic psychiatric problems and behavioral problems requiring intensive mental health treatment. The center proposes a 12 bed facility which would offer intensive treatment and educational oriented programs in conjunction with the local deparmtent of social services, the local school district and the local center for the developmentally disabled. This facility would make possible a reduction in the number of children being inappropriately institutionalized in both psychiatric hospitals and juvenile detention facilities.

Region 2b

Larimer County comprises Planning Region 2b. The 2b district's northern borders are aligned with Wyoming, while to the east is Weld County, to the south Boulder County and on the west Jackson and Grand Counties. Most of Region 2b lies in the South Platte River watershed with the northwest corner of the territory comprising part of the Big Laramie River watershed.

An unusually heavy rainfall recently caused the Big Thompson River, which flows across the southern part of the county, to overflow. The resulting flooding became a major disaster which claimed over 125 lives. The canyon in which the river overflowed is a major highway route, and contained many homes and businesses. Since the canyon is a high risk flood area, consideration is being given to ways of preventing future loss of life. This might result in the relocation of canyon residents to other areas of the county.

The major communities of the county are Fort Collins, Loveland and Estes Park. According to a recent survey, this area is the fourth fastest growing community in the United States. The major industries in the county are agriculture, livestock, education (Colorado State University) and tourism. The terrain of the county ranges from mountain peaks of 14,000 feet and the Continental Divide on the west to the rolling plains of the Poudre and South Platte River Valleys.

1. Existing Services

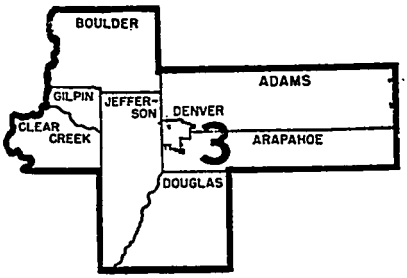
The county is served by the Larimer County Mental Health Center (LCMHC). The agency was recently awarded a federal grant which will enable it to provide a full range of community mental health services. Prior to the award of the federal grant, LCMHC had provided many services above and beyond those expected of an agency with its level of funding. These services included inpatient services, and special programs for alcoholics referred by law enforcement agencies and developmentally disabled persons with mental health problems.

2. Program Needs

Program needs include alternative treatment facilities for all ages, increased services to outlying areas, and increased outreach to the Chicano population. The federal grant and the additional state and local funding available will help meet some of these needs.

The disasterous flood referred to above created many additional demands for services beyond the capacity of the agency to meet with existing resources. The center is applying for special federal funds for counseling services to surviving disaster victims and the families of those who did not survive.

REGION 3



Area: 5,045 square miles
Population: 1,487,594

Region 3 is a 5,045 square mile area encompassing eight counties — Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Gilpin and Jefferson. The region lies directly south of Larimer, Weld and Morgan Counties. It is bounded in the east by Washington County, in the south by Elbert, El Paso, Teller and Park Counties and in the west by Grand and Summit Counties.

Region 3 is largely a metropolitan district and is the most important industrial area of the state. The topography of the territory ranges from level, fertile land in Adams County to the rugged mountains (primarily in Clear Creek and Gilpin Counties) in the western portion of the region.

The South Platte River and a few of its important tributaries — the St. Vrain River, Boulder, Clear and Cherry Creeks — flow through the area and contribute to a small amount of agricultural activity. Most of this farming is limited to Adams County and is accomplished through the use of both dry and irrigated land. There is a limited amount of farming and livestock grazing in Arapahoe, Boulder, Douglas and Jefferson Counties.

The principal economic bases of the region are manufacturing, trade and government services which are concentrated mainly in Denver, the most populous of the state's 63 counties. Recreation and tourism are major industries in the western part of the region.

Mineral extraction plays an economic role of secondary importance in the region. This includes flourspar, sandstone, sand, gravel and clay extraction in the eastern section, and lead, silver, zinc, molybdenum and uranium mining in the mountainous sections of the district.

The state hospital serving Region 3 is the Fort Logan Mental Health Center. This hospital pioneered many of the approaches to community care presently being practiced in many centers and clinics in Colorado and across the country. In addition to Fort Logan and the 14 mental health centers and clinics in Region 3, mental health services are available through Colorado Hospital (a component of the University of Colorado Medical Center), two psychiatric hospitals, several general hospitals, many private practitioners (psychiatrists, social workers, psychologists, nurses, pastoral counselors, etc.) as well as voluntary agencies.

A brief description of the centers and clinics in Region 3 follows.

Adams County Mental Health Center, Inc.

1976-77 Estimated Population: 206,561

1. Existing Services

This comprehensive community mental health center serves the rapidly growing suburban area to the north/northeast of the City of Denver.

It provides a wide range of programs for children, adults and persons in nursing homes. The center is heavily utilized by residents of the community through decentralized offices as well as a variety of specialized programs, notably, partial care, sheltered workshops and a continuum of other 24-hour residential care for the chronically ill. Specific federal grants have provided funding for direct services to children in four school districts through a school mental health program. A child advocacy program offers direct services to children and adolescents in the fifth school district.

2. Program Needs

Areas of need include expanded attention to the large number of nursing home residents who are former psychiatric patients. Additional alternative living facilities are needed because of the large number of persons within the catchment area who require long term care. Additional specialized services for Chicanos are also indicated.

Arapahoe Mental Health Center, Inc.

1976-77 Estimated Population: 153,832

1. Existing Services

This center serves the suburban areas to the south of the City of Denver. It provides comprehensive services through its own decentralized facilities, Fort Logan Mental Health Center and Colorado Psychiatric Hospital. The center initiated action which resulted in the passage of a county bond issue to generate funds for an alternative treatment facility. The agency has also developed excellent consultation and education and children's and alcoholism services.

2. Program Needs

This center will be placing major emphasis on the development of alternatives to inpatient care. Heavy emphasis will also be placed on increased services to aged persons and the Chicano residents of its catchment area.

Aurora Mental Health Center, Inc.

1976-77 Estimated Population: 114,569

1. Existing Services

This center is the most recently developed catchment area program in the mental health system. As the results of the recent approval of its application for a major grant, the center now offers a comprehensive array of mental health services. It will be several months before the center is operating at an optimal level, because of the necessary "gear-up" time.

2. Program Needs

Particular emphasis will be placed on crisis intervention, children's services and alternatives to hospitalization. Also, increased emphasis will be placed on services to the more rural eastern end of the catchment area.

Bethesda Community Mental Health Center

1976-77 Estimated Population: 127,936

1. Existing Services

This program provides comprehensive services to residents of southeast Denver. The program is unique as it is affilated with a private psychiatric hospital program which is utilized for inpatient

services. Emphasis has been placed on evaluation of treatment effectiveness within the services offered.

2. Program Needs

The center recognizes the need for development of alternatives to hospitalization within the catchment area. Also, additional services to minority persons are indicated. Efforts are underway to increase services to young people, the elderly and substance abusers.

Mental Health Center of Boulder County, Inc.

1976-77 Estimated Population: 174,413

1. Existing Services

This is a comprehensive center which serves a diverse catchment area including both urban and rural areas. Programs must therefore be geared to these specific populations. Services in the urban parts of the catchment area emphasize services to young people (including drug abuse services), families and the elderly. Services in rural areas reach the poor and minority groups. Services are readily accessible to residents of the catchment area.

2. Program Needs

This center continues to need to provide a range of services to children and young people because of the nature of its population. Alternative residential treatment facilities are needed, as are a limited number of inpatient beds to replace those previously used in a hospital which had to close its psychiatric ward. Additional services are also needed in rural areas of the county.

Children's and Adolescents' Mental Health Services

(This is a non-catchmented, specialty program)

1. Existing Services

This program provides comprehensive "child-oriented" mental health services in a "child-oriented" facility. In-hospital and outpatient services are provided to children and outpatient care is available to parents of children in treatment. Consultation and education services are also available.

2. Program Needs

This program will continue to play an important role because of its particular emphasis on services to young people in a unique setting. Continued funding and support will be required as the overall hospital program expands. At this point, the hospital is planning a private inpatient program for adolescents. The Division of Mental Health is in support of this expanded service.

Denver Mental Health Center, Inc.

(This is a non-catchmented, specialty program)

1. Existing Services

This clinic provides outpatient treatment with emphasis on individual, longer term therapy for people of middle and lower incomes.

2. Program Needs

This clinic plans to provide expanded outpatient services to the elderly and to continue emphasis on providing its services to lower income clients.

Northwest Denver Mental Health Center (Denver Department of Health and Hospitals)

1976-77 Estimated Population: 169,331

1. Existing Services

This center is a component of the City and County of Denver public health system. In some instances, physical and mental health services are available in the same facility. A wide range of physical and mental health services, plus substance abuse and vocational services are available.

2. Program Needs

This is an area of high need which can utilize virtually any additional services that can be developed. Particular needs include a range of alternative 24-hour care facilities, increased services to children and adolescents and strengthening of consultation and education programs.

Jefferson County Mental Health Center, Inc.

1976-77 Estimated Population: 337,209

1. Existing Services

This comprehensive community mental health center offers comprehensive services to Jefferson, Clear Creek and Gilpin Counties which have a total population of well over 300,000 residents, making it one of the largest in the United States. The main administrative offices are located in Lakewood with branch offices in Arvada, Evergreen, Wheat Ridge/Golden, South Jefferson and Lakewood. Part-time offices serve Idaho Springs and Georgetown.

2. Program Needs

The rapidly expanding population of these suburban and mountain counties has placed growing stress on the center to meet basic service demands. Since staffing patterns have remained more or less constant the past two years, careful utilization of staff time is required to maximize efficiency. Also, there are continuing efforts to place more services in Clear Creek and Gilpin Counties. Alternative residential facilities are a high priority for the center. Additional services to the residents of nursing homes is another primary need in this catchment area.

Servicios de La Raza

(This is a non-catchmented, specialty program)

1. Existing Services

This program provides outpatient and emergency as well as consultation and education services of a specialized nature to the Spanish-speaking community of Denver. The program is relatively new and is currently enjoying increasing utilization by the target group it is programmed to serve.

2. Program Needs

There is need for a partial care program designed to meet the needs of the monolingual client in addition to continuation of the program currently in operation. Consultation and education to other agencies concerning the special cultural factors involved in working with Chicano clients continues to be an area of need in relation to this program.

Southwest Denver Community Mental Health Services, Inc.

1976-77 Estimated Population: 90,713

1. Existing Services

This nonfederally funded center has developed a wide range of comprehensive services for its catchment area. It has placed particular emphasis on alternatives to hospitalization, and the provision of services to children and adolescents. A special program designed to help meet Chicano mental health needs is available. This agency has also pioneered a community corrections program.

2. Program Needs

The center hopes to continue and to broaden its program for alternatives to hospitalization so that need for hospitalization will be reduced even further. This includes not only services to adult clients, but adolescents and alcohol and drug abusers as well. Services to the elderly is an area which needs increased attention.

Park East Comprehensive Community Mental Health Center, Inc.
(formerly Malcolm X Center for Mental Health)

1976-77 Estimated Population: 113,321

1. Existing Services

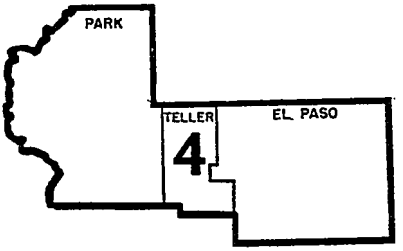
This center provides comprehensive services to the northeast section of Denver. It is the most recent center in Denver to receive federal funding. The center provides centralized intake and diagnostic services, outpatient services at two locations, non-hospital 24-hour care and a day care program. An intensive outpatient program called continuous care is available, as are consultation and education services.

Twenty-four hour care is handled through contractual arrangements with Fort Logan and other hospitals in or near the catchment area.

2. Program Needs

The center recognizes the need for increased services to the elderly, children and adolescents, as well as the Chicano residents of the area. Plans are also being made for a halfway house to serve longer term clients and to complement the short term alternative living facilities now available.

REGION 4



Area: 4,878 square miles
Population: 339,934

Planning Region 4 is composed of three counties - El Paso, Park and Teller, covering 4,878 square miles. El Paso County is primarily urban, while Park and Teller are primarily mountain rural.

El Paso County, stretching along the edge of Rampart Range, includes the metropolitan areas of Colorado Springs, Manitou Springs, Palmer Lake, Fountain, Security, Widefield, Calhan and Ramah.

Teller County consists of foothills and mountain country west of Colorado Springs, and includes Pikes Peak and many small mountain towns, among them Cripple Creek and Woodland Park.

Park County is also a mountainous region containing farms, ranches and small towns, including Fairplay, Hartsell and Bailey.

The catchment area includes four large military installations; Fort Carson Army Base, the Air Force Academy, Peterson Air Force Base and Ent Air Force Base, in addition to the North American Air Defense Command Headquarters in Cheyenne Mountain. Over 40 percent of the area's population are active or retired military personnel and their dependents.

Generally, the area has experienced a growth rate of approximately six percent per year, making the area one of the fastest growing in the state with an estimated population of 339,934, and Colorado Springs the ninth fastest growing city in the nation, with approximately 254,000 residents. Despite such rapid growth, Colorado Springs has the lowest gross household income of the state's nine largest counties, and unemployment is at or above the national rate.

1. Existing Services

This area is served by the Pikes Peak Family Counseling and Mental Health Center, which was formed in 1970 through a merger of Pikes Peak Mental Health Clinic and Family Counseling Service of Colorado Springs. The center's request for a federal staffing grant was approved, but because of presidential impoundment, was never funded. In July 1973, the State of Colorado funded a modified version of this staffing proposal.

The Geographic Outpatient Services Division consists of four major team offices with several satellite offices. Team 1 is the "core city" office and has a staff which reflects the ethnic diversity of its area. Team 2, the Fountain Valley Office, is located in Widefield,

southeast of Colorado Springs. Team 3, the Northeast Office, serves the fastest growing section of the three county area. Finally, Team 4 is located in Manitou Springs and serves all of western and northern El Paso County, as well as Park and Teller Counties. Satellite offices are located in Bailey, Fairplay, Cripple Creek and Woodland Park.

The Hospital Services Unit maintains an 11 bed psychiatric unit at Penrose Hospital. The Adult Day Treatment Unit provides a high intensity outpatient program which allows clients to remain at home and maintain their work, family and social roles. The After-Hours Emergency Services is a 365 day, year-round emergency telephone answering service.

The Special Services Division is comprised of various programs geared to the specialized needs of individuals in the catchment area. Adult Forensic Services is a community-based mental health program for offenders and their families. The program's services include alternative sentencing evaluations for the courts, consultation to staff and inmates of prisons and jails, outpatient group therapy and residential treatment for adult offenders. The Youth Treatment Center offers residential, outpatient and day treatment services to the youth in the community. Budget Counseling provides counseling to families and individuals with financial problems, as well as an extensive education program to prevent such problems.

The Alcohol Services Division offers a variety of programs and treatment intensities specially designed for people with alcohol related problems.

2. Program Needs

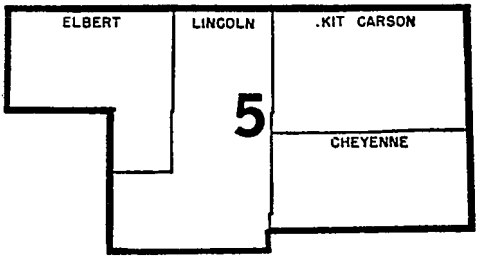
A substantial increase in other 24-hour care beds is needed. Such beds are essential if the center is to attain its objectives related to reducing the rate of inpatient hospitalization and treating clients in the least restrictive setting.

Despite the center's Youth Treatment Center (YTC), the community as a whole has a serious gap in mental health diagnostic and treatment services for children and youth. In addition, the problem of child abuse in this area continues to be acute, and there is an obvious need for both treatment and prevention programs focused on this problem. Additional funding is also needed for improvements in YTC to ensure continued accreditation.

The center is currently underserving the elderly people in its catchment area; additional resources and efforts are needed to provide outpatient and day care programs to maintain the elderly person at an acceptable level of self-sufficiency.

The mental health center is also under pressure to increase outpatient and consultation and education services to the continually expanding population in the catchment area.

REGION 5



Area: 8,401 square miles
Population: 21,158

Cheyenne, Elbert, Kit Carson and Lincoln Counties comprise Region 5, located in the mideastern portion of Colorado. Arapahoe, Washington and Yuma Counties form its northern boundary, the Kansas state line its eastern boundary, Kiowa and Crowley Counties its southern boundary, and El Paso and Douglas Counties its western boundary. The entire region straddles the ridge between the Platte and Arkansas River Valley. Strong agricultural and ranching endeavors are predominant in Region 5.

The distance from markets and raw materials, prevailing freight rates, and other negative factors tend to have a discouraging affect on industry in the area, and thus it is virtually nonexistent.

The Colorado Health Consumer Survey, published in 1971 by the Colorado-Wyoming Regional Medical Program concluded that Region 5 was "the least viable health service region in the state ... it has the most critical shortage of health manpower, and there is no potential regional health care center in the region."

1. Existing Services

At present, the region is served by a part-time clinic headquartered in Flagler. This clinic was the last to develop in the state outside the Denver metropolitan area. The clinic is headed by a part-time director who maintains a private psychiatric practice in Denver, but travels to the catchment area at regular intervals. Presently, out-patient evaluation and treatment programs, alcohol and drug abuse counseling, psychological testing and evaluations, and consultation and education services are offered on a very limited basis.

2. Program Needs

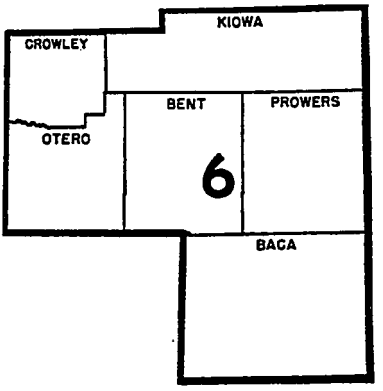
The mental health needs of the region are quite basic. Foremost is, perhaps, the establishment of a full-time outpatient clinic to serve the area. The 3.5 clinical full-time positions are primarily filled by several part-time clinicians from Region 1. A planning grant has been submitted to the Department of Health, Education and Welfare to facilitate the development of comprehensive services for this region. Under this grant concept, Region 1 and Region 5 would be combined so that comprehensive services to this large, isolated area would become feasible.

The area needs inpatient beds for emergency care within the region. Clients are now transported to Colorado State Hospital. Local facilities for short term care and alternative residential facilities would avoid extended absence from the community.

There is considerable need for mental health care of chronic, predominately aged clients. The available nursing homes are not adequately staffed to furnish quality psychiatric care. However, beds could be effectively used in existing nursing homes by upgrading of their staffing patterns.

The region lacks day care facilities for disturbed youth as well as adults.

REGION 6



Area: 9,526 square miles
Population: 57,623

The Region 6 catchment area encompasses six counties in the southeastern corner of Colorado. These are Baca, Bent, Crowley, Kiowa and Otero Counties.

Region 6 includes all of the Arkansas River drainage basin that falls outside the front range corridor. Horse Creek and the Purgatory, Big Sandy, Two Buttes and Cimmaron Rivers, tributaries of the Arkansas River, flow through the area. Other water resources include the John A. Martin, Adobe Creek, Horse Creek, Lake Meredith and Lake Henry reservoirs. The Frying Pan-Arkansas Project, a water resource program, is expected to benefit the area by increasing its water resource base. The region is plagued with seasons of drought followed by severe rainfall, which are characteristic of the Great Plains Region, but still manages to produce significant amounts of sorgham, grain, wheat, corn, broomcorn, sugar beets, alfalfa, commercial vegetables and forage. This output is accomplished through

the use of both dryland and irrigated farming techniques.

Industry has only a nominal foothold in the area, with the manufacturing that does exist primarily oriented toward food processing. Most of this industrial activity is centered around the region's main trade centers of Lamar and La Junta.

The population of the catchment area has demonstrated some decline in recent years, particularly from the rural segment. The area is designated as a poverty area. The number of elderly people and Spanish-speaking persons is above the state average.

The Region 6 catchment area is a rural, agricultural area where relatively few services are readily available. Many residents travel to Pueblo or Colorado Springs for shopping and other services. A trend in this region has been the movement of rural residents to urban areas.

1. Existing Services

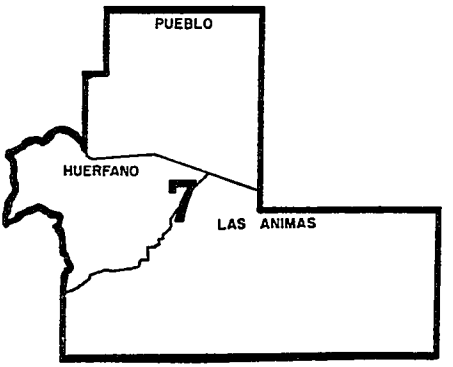
The clinic provides only outpatient and consultation and education services. The clinical staff consists of five full-time professionals, a part-time (two days per month) psychiatric consultant, a part-time nurse, and two secretaries. The clinic has a branch office in Lamar. The Southeast Region ranks first of all Colorado regions in the need for additional publicly-supported mental health services.

2. Program Needs

There is a need for increased mental health services throughout the region. The rural communities are especially seriously underserved due to the distances involved and the limited size of the staff. Need also exists for a drug and alcohol abuse counseling program. Psychological and consultation services to children, especially to

handicapped children and their parents, should be expanded. Expansion of the mental health services to the nursing homes in the catchment area is also a high priority need.

REGION 7



Area: 8,773 square miles
Population: 156,419

The Region 7 catchment area consists of Pueblo, Huerfano and Las Animas Counties. It encompasses fertile valley land, broken prairie and rolling hills in the eastern portion and plateaus and mountains in western areas.

Much of the area is in the Arkansas River watershed. There is farming and ranching in some portions of the region, but they are not the major sources of income.

Pueblo is the major agricultural, commercial and industrial center in the region. The foremost economic asset of this city is the Colorado Fuel and Iron Corporation, which employs approximately 6,000 persons. Plans have been made to close the Pueblo Army Depot, which, in the past, has employed 2,800 persons. This event has and will have a serious

economic impact on the community. Colorado State Hospital is also a major employer, with over 1,300 persons on its payroll.

Trinidad and Walsenburg are this region's secondary trade centers. Both of these communities will benefit economically from the expected expansion of the coal mining industry.

Region 7 has been designated a poverty catchment area. Numbers of poor and ethnic minority residents are high, as is the unemployment rate. Population growth has been relatively slow. All of these social factors have led to development of stresses and tensions in the catchment area. This, in turn, has led to demands for increased social and mental health services.

1. Existing Services

The area is served by the Spanish Peaks Mental Health Center, headquartered in Pueblo. Branch offices are located in Walsenburg and Trinidad. The center provides a full array of services through affiliation with the Colorado State Hospital (CSH) in Pueblo. The center provides outpatient services, emergency services during the daytime and consultation and education services in Pueblo. CSH provides the inpatient services, weekend and night-time emergency services and partial care services in Pueblo. The branch program at Walsenburg provides outpatient and partial care services to adults and outpatient services to children, while the Trinidad branch provides outpatient services for all ages and partial care services for children and school consultation services. The center has also developed a comprehensive alcoholism service program funded by an NIAAA grant. A residential child care facility, called EKOS House, is sponsored by the center. A group home in Trinidad is receiving mental health consultation from the center.

The center was originally established as a joint venture between CSH and the Spanish Peaks Mental Health Clinic. Through a construction and a subsequent staffing grant, a facility for the treatment of children in the region was established on the grounds of CSH. Cottage "D" was staffed by federal funds from the center and by state funds through CSH. Cottage "D" is now operated and funded completely through CSH, and the center is an independent nonprofit agency with a working agreement with CSH, but no joint funding. The center is in its eighth and last year of the staffing grant.

The center serves children through the Rural Child Mental Health Program which provides outreach mental health services to children and families in the rural areas of Pueblo County. It is a cooperative venture with School District 70.

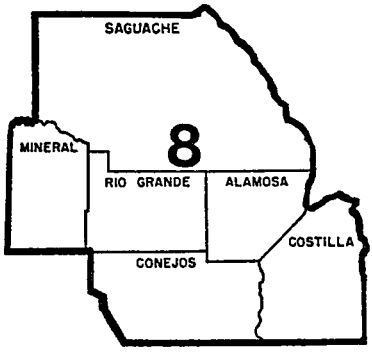
Because the area contains a large Chicano population, the center has developed effective bilingual services. Currently, the center serves as a model for this type of outreach intervention.

2. Program Needs

There is great need for additional resources to develop more extensive outreach services to urban and rural pockets of poverty. There is also a large number of one-parent families that need attention.

Other needs include the following: alternatives to inpatient services in the counties of Las Animas and Huerfano, strengthening of services to minority adult outpatient and partial care clients, provision of centerwide post-institutional follow-up services, increasing outreach mental health services to children and families at risk in areas in addition to School District 70, increasing all programs to the elderly with special emphasis on partial care and inpatient alternatives.

REGION 8



Area: 8,180 square miles
Population: 42,353

Region 8 consists of six counties in the midsouthern section of Colorado. The area consists of the San Luis Valley, the mountain rimmed watershed of the upper Rio Grande River. The valley is a broad flat plain, 50 miles in width and 115 miles long.

The catchment area was settled in the mid-nineteenth century by Spanish-Americans whose culture continues to predominate. This area contains by far the highest concentration of Spanish-speaking persons in the State of Colorado (46.1% of the population). It is also the most contained or most isolated region in the state geographically and perhaps even psychologically.

The population is unusually stable. There tends to be little migration in or out of the region.

Major population centers are Monte Vista and Alamosa. However, even these communities are small (population 4,195 and 8,615 respectively) and offer relatively few services.

The area's economy is based largely on farming, the sportsman/tourist trade and the four year college (Adams State College at Alamosa) with a student-faculty size of 2,300.

By virtually all indicators, the San Luis Valley is among the areas with the most highly ingrained poverty in Colorado. The region ranks high in the percentage of welfare recipients, poor housing, overcrowding, poor health and low income residents.

1. Existing Services

The San Luis Valley Comprehensive Community Mental Health Center is the only private or public mental health treatment facility located in the region. One outstanding feature of the center program is the extensive use of outreach centers and effective use of para-professionals who provide effective, yet economical services. The center operates full-time facilities in Alamosa and Monte Vista. Outreach offices are available in most other communities of the valley. Detoxification facilities for alcoholics are also available.

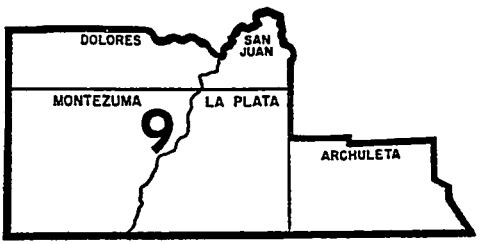
2. Program Needs

The greatest program needs are for locally available inpatient treatment of chronic disorders in children, a community corrections service and an expansion of facilities to treat the adult chronic psychiatric patients requiring hospitalization or other types of residential care.

The high incidence of poverty also contributes to alcoholism and drug abuse. There is strong need for additional resources for alcoholism and drug abuse services. The program has a limited capacity for crisis intervention in the total catchment area. A greater ability to reach out to outlying areas is a chronic need.

Other needs include development of contractual arrangements with local nursing homes to provide services to the aged. Also, strengthened consultation and education services are needed for the entire valley. These services should be aimed at making the public more aware of available services, increasing utilization of services and providing better cooperative efforts among the various valley agencies.

REGION 9



Area: 6,563 square miles
Population: 45,638

Region 9 lies in the southwest corner of Colorado and forms part of the Four Corners area. Archuleta, Dolores, La Plata, Montezuma and San Juan are the district's constituent counties. The San Miguel drainage basin bounds the area to the north, the official dividing line being the borders of San Miguel, Ouray, Hinsdale and Mineral Counties. Conejos County limits the area's eastern extent and New Mexico and Utah border the region to the south and west respectively. The Ute Mountain Indian Reservation along with the Southern Ute Indian Reservation form the southern boundary of the region.

Mineral extraction is a primary economic activity in Region 9. Mining products include pyrite, lead, zinc, silver, copper, gold, sand and gravel. Tourism and lumbering also contribute to the economy of the region with the tourist industry becoming increasingly significant. As the names of the counties suggest, the region has many Chicano and Indian residents. This region has the highest unemployment rate of any region in the state. It is relatively isolated by mountains and distance from the major Colorado cities. Denver is 332 miles away and Colorado State Hospital, which serves this region, is 271 miles away.

1. Existing Services

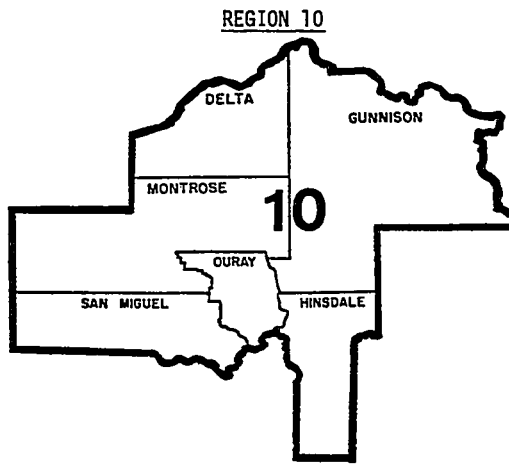
Southwest Colorado Mental Health Center, the only public mental health agency in the area, is an outpatient clinic providing outpatient care, consultation and education and aftercare treatment to patients of all age groups. A special outpatient drug abuse program was also funded three years ago. The staff consists of 12 full-time equivalent positions, and provides services at full-time offices in Durango, Cortez and Ignacio. Satellite offices are located at Pagosa Springs, Dolores and Dove Creek, which are staffed on a part-time basis. Local hospitals are utilized for inpatient care for some clients who are eligible for Meidcare and Medicaid and other third party reimbursements.

2. Program Needs

Southwest Colorado's greatest need is for additional staff to reach out to currently unserved or underserved populations. This catchment area has a high concentration of Native Americans and Chicanos for whom services are only minimally available. The need

for bilingual staff has been of continuing concern to the program.. An application has been submitted under PL 94-63 for a planning grant for FY 76-77. This application has been approved but not funded. The funding of this grant will help meet the need for a plan for the provision of comprehensive mental health services in the region.

Some additional specific program needs are: (a) more local inpatient psychiatric beds; (b) a halfway house and other alternate facilities for ex-state hospital adult psychiatric clients and other adult clients who require a 24-hour residential care facility; (c) a partial care (day care) program in collaboration with the Four Corners Sheltered Workshop at the workshop's facilities in Durango, Cortez and Pagosa Springs; (d) expansion of the center's adult, adolescent and children's outpatient services; (e) a treatment program to meet the needs of elderly people, and (f) expanded consultation and education services.



Area: 9,369 square miles
Population: 48,737

Planning Region 10 consists of Delta, Gunnison, Hinsdale, Montrose, Ouray and San Miguel Counties. This area roughly corresponds to the drainage basins of the Gunnison, Uncompahgre and San Miguel Rivers. The Colorado River drainage basin bounds the district to the south, the official dividing line being the borders of Mesa and Pitkin Counties. The Continental Divide forms a natural boundary to the territory in the east with Chaffee County line as the agreed upon border. The State of Utah lines the region's western boundary.

Agriculture, mining and tourism form the economic base of Region 10. There are several sizeable food processing plants including Holly Sugar Corporation, Skyland Food Corporation and Russell Stover Candies Incorporated. The region's trade centers are Gunnison, Montrose and Delta. Approximately one-sixth of Colorado's federal land holdings are in the region. The wealth of recreational land provides ample facilities for hunting, fishing and skiing.

1. Existing Services

Midwestern Colorado Mental Health Center provides an array of mental health services, including partial care which has been partially staffed by Colorado State Hospital (CSH). The center has contracts with three local hospitals to provide beds for psychiatric patients; some inpatients are sent to CSH. Geriatric patients are also served through local nursing homes where consultation agreements exist. There are full-time staff in Delta and Montrose. Service is provided one day per week in Telluride and Nucal by staff traveling to these areas. Gunnison is served by a staff member who lives in the community.

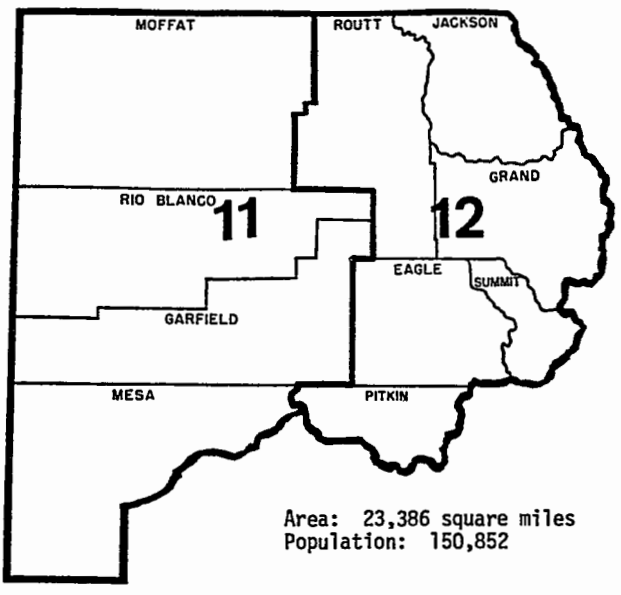
Delivering service across this vast area necessitates a sizeable travel budget. This, along with staff travel time, increases the per client cost. Midwestern is the only public mental health and marriage counseling agency in the catchment area.

The center was recently awarded a second federal grant which will enable it to increase staffing and expand its services to more residents in previously underserved and unserved communities.

2. Program Needs

There is need for more adequate hospital facilities within the catchment area in order to limit the number of patients sent to CSH. Other needs include a high quality mental health program for children and adolescents, alternate residential care facilities for adults, improved 24-hour emergency services, and an expanded partial care program.

REGIONS 11 & 12



Area: 23,386 square miles
Population: 150,852

Regions 11 and 12 are combined into one mental health catchment area, which is composed of 10 counties: Moffat, Rio Blanco, Garfield, Mesa, Eagle, Grand, Jackson, Pitkin, Routt and Summit. The topographical characteristics of Regions 11 and 12 are reflected in the area's economic basis -- specifically agriculture, mining, lumbering, ranching, farming, light manufacturing and recreation. The most important asset of Region 11 is the rich, fertile land of the Colorado River Valley. Stock raising plays a major economic role, with orchard crops important in Mesa County. The Utah and Wyoming state lines border the district to the west and north. The vast mountainous regions in the northwest corner of the state account for 22.3 percent of the total area of the state, and the topography of the region varies greatly from high mountains of the Continental Divide to rolling semi-arid terrain of the western area. All of the Region 12 population is classified as rural dwellers, while in Region 11 the population is equally divided between urban and rural communities.

Both Regions 11 and 12 have vast potential energy resources in their coal and oil shale reserves.

1. Existing Services

Colorado West Regional Mental Health Center is the comprehensive mental health center which serves Regions 11 and 12. The center is comprised of a central administrative office in Glenwood Springs and four affiliates with subregional offices in the following communities: Grand Junction, Glenwood Springs, Granby and Steamboat Springs. In addition to providing full-time service in the above listed communities, full-time services are also available in Eagle, Breckenridge, Aspen, Craig, Rangely and Meeker. The affiliates provide outreach services on a regular basis in Vail, Frisco, Minturn, Redcliff, Rifle, Oak Creek, Walden, Kremmling, Collbran and Fruita. Through these programs,

service can be delivered to small communities unable to support full-time clinics and thus make service available to persons unable to travel to larger centers. The decentralized programming approach has relied heavily upon community and staff involvement in designing services responsive to the widely diverse and unique needs of the many rural communities served. The services vary in emphasis from community to community, but a full range of services is available in the catchment area.

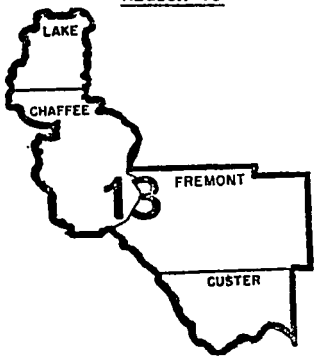
The center has actively sought and obtained funding from various sources to build a very effective program, and has made excellent use of volunteers located throughout the ten counties. As of July 1, 1976, state hospital service responsibility for Region 12 was assumed by Fort Logan. CSH continues to provide services to Region 11.

2. Program Needs

The major need is for readily available hospital beds located close to the community where the patient lives, and for other 24-hour care programs in the various communities.

These two regions project substantial population growth in the next several years and additional financial resources are required to keep up with the increasing population. The persons attracted by the increase in mining activity have made heavy demands on the center for such services as marriage counseling, alcoholism counseling and family counseling.

REGION 13



Area: 3,715 square miles
Population: 45,824

Chaffee, Custer, Fremont, and Lake Counties constitute the 3,715 square mile area designated as Planning Region 13. The mountainous counties of Regions 10, 12 and 4 (Gunnison, Pitkin, Eagle, Summit and Park) surround the northern half of the district and Regions 7 and 8 frame the southern portion of the territory.

Both the Colorado State Penitentiary and the State Reformatory are located in this catchment area.

Mining is a major industry in Region 13. Agriculture, tourism, lumbering and recreation are other important sources of income. Approximately 80 percent of the world's supply of molybdenum is produced near Climax by American Metal Climax Incorporated, which employs over 2,000 persons.

The primary trade centers of Region 13 are Canon City, Salida, Leadville and Buena Vista.

1. Existing Services

West Central Mental Health Center is the Region 13 mental health agency. The center was recently awarded a federal grant which, along

with increased state and local funding, will enable it to provide a full range of services to its catchment area.

2. Program Needs

Specific service needs which will be addressed include locally available inpatient psychiatric services, additional outpatient services throughout the region for all age groups, residential alternatives to inpatient care, day care, emergency "hot-line" services and 24-hour coverage, consultation and education services to agencies such as schools, courts, social services and law enforcement agencies, prescreening services to courts and public agencies, and expanded alcohol counseling services. This region has a high percentage of persons over age 65; special efforts are needed to reach this population.

B. REVIEW PROCESS FOR CATCHMENT AREAS

According to federal guidelines, the population of a catchment area is to be between 75,000 and 200,000. The upper and lower population limits can be waived by DHEW at the time of approval of a center for federal funding. After a center has been awarded a federal grant, if any variation in the population of an area reduces it below the minimum or increases it above the maximum by more than 25 percent, a DHEW waiver must be sought or the catchment area must be enlarged or subdivided as necessary to bring it within the prescribed size.

At least every five years the Division of Mental Health shall review catchment area boundaries to determine what adjustments are necessary. This process will be coordinated with the State Health Planning and Development Agency. The criteria to be used in conducting the review will include:

1. The sizes of catchment areas must be such that the services to be provided through centers and their satellites are promptly available and accessible.
2. The boundaries of catchment areas must conform to the extent practicable, with relevant boundaries of political subdivisions, school districts and Health Service Areas.
3. The boundaries of catchment areas must eliminate, to the extent possible, barriers to access to the services of the catchment area centers, including barriers resulting from an area's physical characteristics, residential patterns, economic and social groupings and available transportation.

C. RANKINGS OF CATCHMENT AREAS

1. Procedures Used in Ranking

In order to determine the relative need for additional mental health services among the various catchment areas, a need assessment study was performed in April 1976. This study included the following two parts:

a. an inventory of existing facilities; and

b. a need survey based on social indicators.

The inventory of existing facilities consisted of a form based on NIMH inventory definitions, and completed by the community agency responsible for each catchment area. The inventory collected data on the number and type of inpatient and other 24-hour care beds, as well as on mental health manpower available in various treatment intensities. The data were returned to the state office for compilation and analysis, and a set of indicators to assess the degree of resources available in each catchment area were chosen. A complete description of the study and the final ranks are shown in Appendix IV.

The second part of the study, the social indicator analysis, was based on the Mental Health Demographic Profile System (MHDPS). This data system provides socio-economic and other demographic information taken from the 1970 census. Eleven indicators of mental health need were chosen, and on the basis of these, the catchment areas ranked. A full description of this study along with the final ranks are shown in Appendix V.

In order to obtain a single ranking of the catchment areas, the ranks of the two studies were combined. The following formula was used: Final Score = (1/2 of the rank on the inventory survey) + (the rank on the social indicator survey). Thus, the social indicators were given twice the weight of the resources indicators. This was done for two reasons:

a. The social data were all collected in the same way (from the Census Bureau) while the inventory of resources was produced by many different people in different places. Therefore, it was felt that the latter represented less comparable data.

b. Since reporting of certain types of resources was optional on the facilities inventory, these resources were not considered in the analysis. This again led to the feeling that the inventory represented "softer" data.

2. Rankings of the Catchment Areas

The table below shows the final ranks of the catchment areas, with a rank of "1" indicating the greatest need. As mentioned above, the rankings on the facilities inventory and the social indicators survey are shown in Appendices IV and V; the combined score is shown in Appendix III. All supporting data are also included in the appendices for the reader wishing complete detail. These rankings, or other similar data developed by or outside the DMH, will be shared with affected centers and clinics and with technical experts to obtain input on limitations and applicability of results, prior to use for funding decisions or recommendations.

LISTING OF CATCHMENT AGENCIES
IN RANKED ORDER

Rank*	
1	SE Colorado
2	NW Denver
3.5	Midwestern W Central
5	SW Colorado
6	San Luis Valley
7.5	Park East Spanish Peaks
9.5	NE Colorado Weld
11	Colorado West
12	Adams
13	Aurora
14.5	E Central Larimer
16	Pikes Peak
17.5	Bethesda Jefferson
19	SW Denver
20	Boulder
21	Arapahoe

*Rank of "1" indicates greatest need.

D. PROGRAM FOR DEVELOPMENT OF COMMUNITY MENTAL HEALTH RESOURCES

In keeping with the principle that mental health services must be made available to all citizens of the state, regardless of ability to pay, the Division of Mental Health will work aggressively to develop additional resources to help meet the mental health service needs of all citizens. These efforts will include well planned presentations to legislative groups, and a relentless search for alternative sources of funding.

The Division has been actively working toward a more constructive, cooperative relationship with all elements of the mental health service system and other systems such as the state and federal substance abuse authorities.

In fiscal year 1975-76 the state provided 43.5 percent of the total funds for the mental health system. Despite recent federal awards to centers, continuing emphasis must be placed on increased state fiscal participation. In order to justify increased state funding, a better system of need determination and cost accounting will be necessary. The Division has been actively developing its accounting capability and will continue to do so in the future.

The Division will aggressively pursue various potential sources of third party income, including Title XX contracts, to obtain additional funding for mental health services. A closer working relationship will be established with the Department of Social Services to insure that funds available through this department are directed, to the maximum extent possible, to mental health agencies.

There is need for legislation which will make Title XIX (Medicaid) funds more directly available for recipients of mental health services. The Division will work toward the passage of such legislation.

Each community mental health program in the state will be responsible for mounting a vigorous program to secure additional funding from counties and municipalities. In those cases where counties or cities do not participate in mental health funding, every effort will be made to educate local officials on the importance of maintaining a viable local mental health program. Close collaboration with the new Health Systems Agencies will be essential.

The Division recognizes the need for centers/clinics to reexamine their fee structure in order to insure that it is reasonable and all fees that can be collected are collected. Toward this end, special attention will be directed toward each program's fee structure and collections during annual site evaluations.

E. FACILITIES

1. Plans for Comprehensive Services

As previously indicated, the state is divided into twenty-one catchment areas. Seventeen of these areas are served by comprehensive centers, and four receive services from clinics which have achieved varying degrees of comprehensiveness. All clinics provide at least outpatient and consultation and education services, and their service offerings are supplemented by the two state hospitals.

The goal is to have all catchment areas covered by comprehensive centers. During the past month, three clinics (Aurora, West Central

and Larimer County) have been awarded initial operations grants; one clinic (Southwest Colorado) has applied for a planning grant; and the Division of Mental Health has applied for a planning grant for East Central and Northeast Colorado Mental Health Clinics. The plan is to merge East Central and Northeast Colorado Clinics to form one strong, well staffed agency. The rationale for combining the two catchment areas is as follows:

a. geographic contiguity and similarity of the two areas;

b. social homogeneity of populations;

c. similarity of mental health problems; and

d. when the two catchment areas are merged, they will have a total population of 86,000 and could thus meet the minimum DHEW population requirement of 75,000 without a waiver.

When planning has been completed, an application for an initial operations grant will be submitted.

When the above actions are accomplished, only two catchment areas (Southeastern Colorado and Southwest Colorado) will be without comprehensive services. The goal is to promote initiation of an initial operations grant application for these catchment areas within the next three years.

2. Construction, Purchase and Remodeling of Facilities

Both existing and planned centers are required to periodically review their facilities requirements. Emphasis is placed on leasing or remodeling existing facilities rather than new construction. The criteria used to determine priorities for construction funds have, in the past, been those incorporated in PL 88-164, Title II (Construction of Community Mental Health Centers). The need criteria to be used

effective July 1, 1976, are those incorporated in the ADAMHA guidelines for the preparation of this plan. The rankings of catchment areas on the basis of need are found in Appendix III.

APPENDICES

AGENCIES AND ORGANIZATIONS
FROM WHICH
INPUT WAS REQUESTED AND/OR RECEIVED

*a. Alcohol, Drug Abuse & Mental Health Administration - Region VIII

b. American Federation of State, County and Municipal Employees

c. Chicano Mental Health Coalition (Metro-Denver)

*d. Chicano Mental Health Planning Symposium

*e. Citizen's Advisory Committee of the Fort Logan Mental Health Center

*f. Colorado Association of Community Mental Health Centers and Clinics

g. Colorado Hospital Association

h. Colorado Nurses Association

i. Colorado Psychiatric Society

j. Colorado Psychological Association

k. Councils of Government

- Colorado West Area

* - Denver Regional

- District 10 Regional Planning Commission

- Huerfano-Las Animas Area

* - Larimer-Weld Regional

- Lower Arkansas Valley

- Northeastern Colorado

- Northwest Regional

- Pikes Peak Area

- Pueblo Area

* - San Luis Valley

- Regions 5, 9 and 13 (see Department of Local Affairs)

*l. Denver Department of Health and Hospitals

m. Denver Mental Health Advisory Board

n. Department of Education Central Office

(1) Division of Special Education

*o. Governor's Task Force on Children

p. Department of Health Central Office

* (1) Division of Alcohol & Drug Abuse

* (2) Division of Comprehensive Health Planning

* (3) Health Facilities Division

* (4) Community Health Services Division (MH Nursing Consultant)

* (5) Administrative Services Division (Planning Section)

q. Human Services Cabinet Council

*r. Human Services, Inc.

s. Health Systems Agencies

(1) Central-Northeastern Colorado Health Systems Agency, Inc. (Area 1)

(2) Southeastern Colorado Health Systems Agency, Inc. (Area 2)

(3) Western Health Systems Agency, Inc. (Area 3)

*t. Department of Institutions Central Office

* (1) Division of Corrections

(2) Division for the Deaf and Blind

(3) Division of Developmental Disabilities

* (4) Division of Mental Health (Central Office)

* (a) Fort Logan Mental Health Center

* (b) Colorado State Hospital

* (c) Twenty-four mental health centers and clinics

* (5) Division of Youth Services

u. Joint Budget Committee

v. Juvenile Delinquent Advisory Board

w. Department of Local Affairs - Division of Planning
(Regional Clearinghouse for Regions 5, 9 and 13)

*x. Lutheran Service Society

*y. Mental Health Association of Colorado

*z. Mile High United Way

aa. National Association of Social Workers

bb. National Council on Alcoholism

*cc. Office of State Planning and Budgeting

dd. PEAK Incorporated (alcoholism and drug outpatient program)

ee. Department of Social Services Central Office

* (1) Division of Aging

(2) Division of Medical Assistance

* (3) Title XX Division (Family & Children's Section)

ff. South Dakota Department of Social Services - Office of Mental Health

*gg. State Mental Health Plan Subcommittee - Mental Health Association

hh. State Plan Committee of Developmental Disabilities Council

ii. University of Colorado at Denver - Psychology Department

jj. University of Colorado Medical Center

(1) JFK Center

(2) Psychiatry Department

kk. Washington House (Adams County Alcoholism Treatment Program)

ll. Western Interstate Commission on Higher Education

mm. Wisconsin Department of Health and Social Services

* agencies and organizations from which input into the plan was received

CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

I. INTRODUCTION

The Division of Mental Health (DMH) applied for and received a small Research and Development grant from the National Institute of Mental Health in 1975. The grant was the culmination of a year of dialogue between the DMH and the NIMH Minority Center focusing on ways in which the state and federal government could cooperate in program planning and development in the area of minority mental health. It was agreed from the outset that if wide-impact minority oriented programs were to become reality, the development process must begin with minority participation in the state planning process. The Symposium Grant therefore was designed specifically to pioneer a planning process in Chicano services that would have direct impact on the State Mental Health Plan.

The Symposium was patterned to initiate that process by convening community mental health center administrators, DMH staff and Chicano experts to collectively examine the issues and produce a plan that the DMH could incorporate into the master plan. Four areas of immediate importance were addressed for the duration of the Symposium held early in 1976. Specifically those areas addressed were: (1) service programs; (2) unit cost; (3) legislation; and (4) research. The following five year plan is a compilation of the products of the Symposium sessions coupled with recommendations for other ethnic minority mental health group needs.

The largest ethnic minority in Colorado is the Chicano, comprising approximately 17% of the state's population. Although Chicanos, as a distinct cultural and ethnic group, reside in every mental health catchment area of the state, they are concentrated in the small towns of southern Colorado and in the barrios of the cities along the front range of the Rocky Mountains. The city of Denver alone contains an estimated 90,000 Chicanos most of whom reside on the westside area of the city. It makes sense then, to address the needs of the state's largest ethnic minority group as the first step to complying with PL 94-63.

The Symposium Follow-Up Committee (statewide) and the Metro-Denver Chicano Mental Health Coalition submit the following guidelines for a planned approach to meeting the special mental health needs of the ethnic minority population of the State of Colorado.

II. FIVE YEAR PLAN FOR CHICANO MENTAL HEALTH SERVICES, RESEARCH AND DEVELOPMENT.

A. Phase 1 - Fiscal Year 1976-77

Goal One: Assessment of Chicano mental health services on a statewide basis.

Interpretation: There is a critical need to conduct a statewide inventory to determine the extent and quality of services being delivered to persons of Spanish-speaking descent whose command of English is limited.

Objective 1 - Conduct a survey of each catchment area of the state to gather descriptive information as to the kinds of efforts being made to serve the limited English-speaking Chicano client.

Objective 2 - Modify the state data system currently feeding information to the Division of Mental Health (DMH) in order to gather data on Spanish-speaking clients relative to level of disruption and service delivered.

Goal Two: Develop a formalized, constructive, collaborative relationship between the DMH and representatives of the Chicano community.

Interpretation: There is a need to develop a regular liaison process between the DMH and various elements of the Chicano community in order to exchange information and expertise. Such a liaison function can be achieved through the Division's own Chicano Symposium Committee which has statewide representation.

Objective 1 - Formalize the relationship between the Director of DMH and the Chicano Symposium such that regular meetings are held to exchange information and maintain the thrust of the Chicano plan.

Objective 2 - The liaison process will serve as the central mechanism by which the Chicano plan is translated into specific action by DMH with the help of outside groups.

Goal Three: DMH will initiate plans to establish pilot research and demonstration projects designed to collect data on models appropriate for serving Chicanos.

Objective 1 - DMH support for the Chicano inpatient unit proposal for Colorado State Hospital submitted to NIMH will continue.

Objective 2 - In its 1977-78 budget request the DMH will ask for state funds to establish at least one research and demonstration project in the state designed to test out an appropriate outpatient service model for Chicano clients. A similar effort will be made to secure federal funds.

B. Phase II - Fiscal Year 1977-78

Goal One: DMH will build into the site evaluation format specific criteria for assessing the adequacy of services to Chicanos by community programs.

Objective 1 - Each center/clinic shall comply or shall demonstrate plans to comply with PL 94-63 pursuant to requirements for serving clients of limited English-speaking ability, (Section 206, D).

Objective 2 - Each center/clinic will be required to demonstrate that its staff has the cultural sensitivity and linguistic skill to serve the Spanish-speaking population through a program that is outreach oriented.

Objective 3 - Each center/clinic will be required to include training in services to Chicanos as part of its ongoing inservice training program.

Goal Two: The DMH staff development program shall develop and implement a program component aimed at Chicano client services.

Objective 1 - The staff development program will begin to develop and apply a curriculum on Chicano services for staff development on a statewide basis.

Goal Three: DMH will evaluate the model used in addressing Chicano needs to examine the needs of other minority groups.

Objective 1 - Blacks

Objective 2 - Asians

Objective 3 - Native Americans

Goal Four: During fiscal year 1977-78, DMH will fully implement the research and development projects initiated under Phase 1.

Interpretation: It is understandable that the start-up time on such programs may straddle fiscal years and/or the procurement of federal funds is often a protracted process.

Objective 1 - Each project will have a well-designed evaluation component that will yield data on its effectiveness and efficiency.

Objective 2 - Close attention will be paid to the transportability of each model to other areas of the state.

C. Phase III - Fiscal Year 1978-79

Goal One: By July 1, 1978, each community mental health program and Fort Logan will be in full compliance with PL 94-63 as it pertains to clients of limited English-speaking ability.

Objective 1 - Each center/clinic will comply with Section 201(b)(2) of PL 94-63 as it pertains to the elimination of cultural and linguistic barriers to services.

Objective 2 - Each center/clinic will comply with Section 206(c)(1)(D) of PL 94-63 as it pertains to services to clients with limited English-speaking ability.

Goal Two: DMH will be instrumental in the development of three additional research and demonstration projects on alternative models for Chicano services.

Objective 1 - Each new model will explore services in a different modality with the aim of systematically investigating all of the essential services mandated by PL 94-63.

Goal Three: The DMH will finalize plans for a forum in which the mental health needs of other significant minority groups will be assessed.

Objective 1 - DMH will assess the feasibility of conducting a combined symposium in which the needs of Blacks, Asians, and Native Americans are analyzed and a plan of action is developed.

D. Phase IV - Fiscal Year 1979-80

Goal One: DMH will request state funds for services to be directed at culturally and linguistically different clients, e.g., limited English-speaking ability, as part of the DMH request for state funds.

Objective 1 - The DMH will write into its budget request an amount sufficient to maintain research and development programs with state funds.

Objective 2 - DMH will request funds to program for clients of limited English-speaking ability in every catchment area with at least 5% Chicanos.

E. Phase V - Fiscal Year 1980-81

Goal One: By the end of the fiscal year every catchment area with 5% Chicano population will have developed the capacity to serve that population in its own language and cultural context.

Objective 1 - Each catchment area with 5% or more Chicanos will have bilingual, bicultural staff in a quantity that corresponds to the percentage of that population in the catchment area.

Goal Two: The DMH budget request for state funds will routinely contain funds for services to the limited English-speaking client.

Appendix III, Page 1

RANKINGS OF CENTERS/CLINICS

The following table shows the computation of the final need rankings of the catchment areas. The "weighted score" of a catchment area was based on a combination of its rank on the resources inventory and its rank on the social indicator study. The latter was weighted twice as heavily as the former. The "weighted score" was then ranked to yield the "final ranks."

NEED RANKINGS OF THE CATCHMENT AREAS

	CATCHMENT AREA	Rank on Resources Inventory	Rank on Social Indicators	Weighted Score	FINAL RANK
1	NE Colo	6	12	15	9.5
2a	Weld	12	9	15	9.5
2b	Larimer	13	14	20.5	14.5
3a	Adams	9.5	13	17.8	12
3b	Arapahoe	16	20	28	21
3c	Boulder	18	17	26	20
3d	Jeffco	2	21	22	17.5
3e	Bethesda	8	18	22	17.5
3f	NW Denver	14	1	8	2
3g	Park East	11	8	13.5	7.5
3h	SW Denver	17	15	23.5	19
3i	Aurora	4	16	18	13
4	Pikes Peak	20	11	21	16
5	E Central	3	19	20.5	14.5
6	SE Colo	1	4	4.5	1
7	Span Peaks	21	3	13.5	7.5
8	San Luis	19	2	11.5	6
9	SW Colo	9.5	5	9.8	5
10	Midwestern	7	6	9.5	3.5
11,12	Colo W	15	10	17.5	11
13	W Central	5	7	9.5	3.5

INVENTORY OF EXISTING FACILITIES

A. PROCEDURES FOR THE FACILITIES INVENTORY

In April 1976, the Colorado Division of Mental Health conducted an Inventory of Existing Facilities. Forms and instructions were distributed to the community agency recognized by the state as having responsibility for the given catchment area. These agencies collected the data for their catchments, completed the forms, and returned them to the State Division for compilation and analysis.

The form was designed to collect basic information according to NIMH Inventory definitions. The term used in Colorado for transitional/intermediate care is "other 24-hour care." This latter term appears on the form and in this dicussion for clarity to Colorado planners.

The Inventory was also used to gather additional information on beds actually utilized by the catchment community agency and on beds needed.

From the information collected by catchment areas, most of the data from Colorado's two state hospitals (Colorado State Hospital and Fort Logan Mental Health Center) were deleted from the resources of the catchment areas in which they are located (7 and 3e, respectively). This was done because the majority of resources of the two hospitals are not in fact available to these two catchment areas; i.e. the hospitals serve an area much larger than just the two catchment areas in which they are located. The present procedure, however, does include those portions of the state hospital data which are used by catchment areas 7 and 3e, respectively, since these do represent resources available within the catchments. The remainder of state hospital data appear in a separate table, not identified with any particular catchment area(s).

Also, the data used in the present rankings exclude all resources related to those facilities which were optional in completion of the Inventory. These types were excluded to assure statewide comparability, since these facilities were reported on an optional basis.

B. INDICATORS: JUSTIFICATION AND WEIGHTING

From the completed forms, indicators were selected by the Division of Mental Health for ranking Colorado's catchment areas in terms of resources. General considerations in the selection of these indicators included availability and accessibility of care, actual resources utilized by or in coordination with the catchment agency, and local (government and private) initiative in providing care.

With these considerations in mind, the following indicators were selected:

1. number of acute inpatient beds per 100,000 population (weight = .25);
2. number of other 24-hour care beds per 100,000 population (weight = .50);
3. total number of beds (inpatient and other 24-hour) with ownership by local government or private nonprofit per 100,000 population (weight = .10);
4. number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population (weight = .75);
5. number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population (weight = .10).

All data used in the above rates were collected in April, 1976 by the statewide Inventory of Existing Facilities. Following are respective descriptions of these indicators and the rationale for their selection and weighting:

1. Number of acute inpatient beds per 100,000 population.

   This rate of non long-term beds, following Federal Inventory definitions, was selected on the basis that there would probably be beds in such facilities as general hospital psychiatric services, CMHC's, or the like, to which population in an area would have greater immediate access than to long-term inpatient beds.

   This rate is assigned a base weight of .25 from which the weights of the remaining four indicators are constructed.

2. Number of other 24-hour care beds per 100,000 population.

   One of the highest priorities of the Colorado Mental Health Plan is the local provision of alternatives to inpatient hospital care. Special programs to attend to this priority often employ other 24-hour care beds. Therefore, this measure of other 24-hour care beds within each catchment receives the higher weight of .50.

3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.

   This is a further refinement of the above bed-rate indicators with the additional qualification of ownership from the Inventory form. Long-term beds are included here under the assumption that with this ownership restriction, such beds would be used largely by catchment area residents.

An additional weight (.10) has been assigned because the two types of agencies here may be assumed to have the greatest accessibility and least restrictions for catchment area residents. Additionally, this rate provides an indication of local initiative and commitment for mental health services.

4. Number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population.

   This non-24-hour care personnel hours measure was selected on the basis that these treatment intensities are more readily accessible (i.e., where population in an area might first turn for services). Also, there are likely to be less personnel involved in nonpatient care activities than would be the case in 24-hour treatment intensities. Additionally, these intensities are generally closest to home and represent the least restrictive types of treatment. These data, from the Inventory forms, represent all staff providing or administering client care and exclude clerical and maintenance staff. Private practice hours are deleted, as this is an optional variable on the Inventory.

   Since it is assumed that non-24-hour care services may be more easily available than 24-hour beds to a population in an area both in terms of numbers of such services and general accessibility, this rate is given a higher weight (.75) than the above indicators.

5. Number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population.

This final indicator qualifies the previous rate by restricting ownership to local government or private nonprofit, for the identical reasons cited in the discussion to indicator 3 above. Thus, these resources receive a little extra weight (.10) than they did in indicator number 4 above.

C. RANKING PROCEDURES

The final ranking of catchment areas is derived by summing the weighted ranks on each of the five indicators:

Catchment Area's Final Weighted Score = $\sum w_i r_i$ where i ranges from 1 to 5, r_i is the area's rank on the i_{th} indicator, and w_i is that indicator's weight.

Therefore, a Catchment Area's Final Weighted Score = $.25r_1 + .50r_2 + .10r_3 + .75r_4 + .10r_5$.

The catchment areas are then ranked on the basis of their final scores. This final ranking serves as the prioritization of the catchment areas within the Survey of Mental Health Resources.

The following tables present:

a. Final Ranks

b. Rankings on Resource Indicators and Final Weighted Scores

c. Resource Indicator Scores

d. Data for Computation of Resource Indicators

e. Regional Summary of Existing Facilities (Excluding Optional Agencies)

f. State Hospital Resources Not Assigned to Any Catchment Area

FINAL RANKS

CATCHMENT AREA		FINAL RANKS*
1	NE Colo	6
2a	Weld	12
2b	Larimer	13
3a	Adams	9.5
3b	Arapahoe	16
3c	Boulder	18
3d	Jeffco	2
3e	Bethesda	8
3f	NW Denver	14
3g	Park East	11
3h	SW Denver	17
3i	Aurora	4
4	Pikes Peak	20
5	E Central	3
6	SE Colo	1
7	Spar Peaks	21
8	San Luis	19
9	SW Colo	9.5
10	Midwestern	7
11,12	Colo W	15
13	W Central	5

*The Rank 1 represents the highest need.

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Rankings on Resource Indicators
and
Final Weighted Scores

CATCHMENT AREA		Rankings on * Indicators 1	2	3	4	5	Final Weighted Scores
1	NE Colo	4.5	9	5	9	9	13.8
2a	Weld	14	18	12	8	8	20.5
b	Larimer	10	8	6	18	19	22.5
3a	Adams	4.5	10	7	12	12	17.0
b	Arapahoe	13	14	16	15	16	14.8
c	Boulder	15	19	17	13	14	26.2
d	Jeffco	4.5	5	3	2	3	5.7
e	Bethesda	16	13	20	3.5	1	15.2
f	NW Denver	18	2.5	10	20	20	23.8
g	Park East	21	6	19	10	10	18.7
h	SW Denver	9	16	9	17	17.5	25.8
i	Aurora	4.5	7	4	5	5	9.3
4	Pikes Peak	17	20	18	16	13	29.4
5	E Central	4.5	2.5	1.5	7	6	8.5
6	SE Colo	4.5	2.5	1.5	1	2	3.6
7	Span Peaks	20	21	21	19	17.5	33.7
8	San Luis	4.5	15	14	21	21	27.9
9	SW Colo	19	2.5	15	11	11	17.0
10	Midwestern	12	11	8	6	7	14.5
11 & 12	Colo W	11	17	13	14	15	24.6
13	W Central	4.5	12	11	3.5	4	11.2

*1. Number of acute inpatient beds per 100,000 population.
2. Number of other 24-hour care beds per 100,000 population.
3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.
4. Number of weekly non-24-hour care personnel hours per 1,000 population.
5. Number of weekly non-24-hour care personnel hours in agencies with local government of private nonprofit ownership per 1,000 population.

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Resource Indicator Scores

CATCHMENT AREA		Indicators * 1	2	3	4	5
1	NE Colo	0	15.3	15.3	10.0	10.0
2a	Weld	16.1	50.0	29.5	9.9	9.9
b	Larimer	7.6	11.0	18.5	17.5	17.5
3a	Adams	0	18.7	18.7	11.3	11.3
b	Arapahoe	15.2	33.0	48.1	15.1	15.1
c	Boulder	17.1	54.1	62.6	13.1	13.1
d	Jeffco	0	1.5	1.5	4.3	4.3
e	Bethesda	8.2	31.3	22.4	4.6	3.2
f	NW Denver	35.0	0	24.6	33.4	33.4
g	Park East	83.2	4.1	83.2	10.1	10.1
h	SW Denver	1.0	38.8	24.5	16.6	15.9
i	Aurora	0	10.6	10.6	5.0	5.0
4	Pikes Peak	24.5	54.8	67.1	15.2	11.8
5	E Central	0	0	0	8.7	6.7
6	SE Colo	0	0	0	3.6	3.6
7	Span Peaks	80.1	158.3	139.9	29.1	15.9
8	San Luis	0	36.1	36.1	36.3	36.3
9	SW Colo	40.2	0	40.2	10.9	10.9
10	Midwestern	12.8	21.3	21.3	8.4	8.4
11 & 12	Colo W	8.0	44.2	32.6	14.7	14.7
13	W Central	0	26.6	26.6	4.6	4.6

*1. Number of acute inpatient beds per 100,000 population.
2. Number of other 24-hour care beds per 100,000 population.
3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.
4. Number of weekly non-24-hour care personnel hours per 1,000 population.
5. Number of weekly non-24-hour care personnel hours in agencies with local government of private nonprofit ownership per 1,000 population.

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Data for Computation of Resource Indicators

CATCHMENT AREA	1975-76 Population	Resource Indicator Data * 1	2	3	4	5
1	65 524	-	10	10	658	658
2a	111 922	18	56	33	1108	1108
b	118 653	9	13	22	2082	2082
3a	203 607	-	38	38	2299	2299
b	151 633	23	50	73	2285	2285
c	175 620	30	95	110	2309	2309
d	333 764	-	5	5	1423	1423
e	137 248	25	43	168	627	437
f	182 944	64	-	45	6104	6104
g	122 538	102	5	102	1240	1240
h	98 006	1	38	24	1628	1562
i	112 930	-	12	12	560	560
4	302 652	74	166	203	4593	3578
5	19 818	-	-	-	172	132
6	60 187	-	-	-	215	215
7	152 258	122	241	213	4426	2418
8	41 578	-	15	15	1509	1509
9	42 330	17	-	17	460	460
10	46 889	6	10	10	394	394
11 & 12	137 955	11	61	45	2034	2032
13	45 097	-	12	12	209	209

*1. Number of acute inpatient beds.
2. Number of other 24-hour care beds.
3. Total number of beds with ownership by local government or private nonprofit.
4. Number of weekly non-24-hour care personnel hours.
5. Number of weekly non-24-hour care personnel hours in agencies with local government or private nonprofit ownership.

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REGIONAL SUMMARY OF EXISTING FACILITIES

- EXCLUDING OPTIONAL AGENCIES -

CATCHMENT AREA	- Number of Beds - Inpt Acute	Inpt Long Term	Other 24-Hour	- Number of Personnel Weekly Hours - Inpt	Outpt	Partial	Emer	Oth-24	Total
1			10		462	142	54	38	696
2a	18		56	490	945	113	50	756	2354
b	9		13	1447	1554	216	312	289	3818
3a			38	60	1603	568	128	504	2863
b	23	74	50	2663	1788	360	137	858	5806
c	30	35	95	807	1621	403	285	1456	4572
d		3	5	91	1105	180	138	107	1621
e	25	100	43	1059	387	218	22	280	1966
f	64			2900	4064	1280	760		9004
g	102	1	5	40	600	600	40		1280
h	1	2	38	180	1036	515	77	705	2513
i			12	70	400		160	70	700
4	74	22	166	5170	3581	636	376	2753	12516
5					132	40			172
6					215				215
7	122	26	241	5548	3297	1257	419	1791	12312
8			15	5	1231	268	10	204	1718
9	17				460				460
10	6		10		231	130	33	113	507
11 & 12	11		61	35	1444	255	335	438	2507
13			12		189		20		209

State Hospital Resources Not Assigned to Catchment Areas

Name & Address of Resource	Ownership of Facility	Type of Facility	NUMBER OF BEDS			Mental Health Personnel Weekly Hours						
			Inpatient		Transitnl/ Intermed (Other 24-Hr Care)	Total	Facility Based					
			Acute	Long Term			Inpatnt Treatmt	Outpatnt Treatmt	Partial Treatmt	Emergcy Care	Trnsitnl/ Intermed (Other 24-Hr Care)	Priva Prct
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13
Colorado State Hospital 1600 W. 24th Street Pueblo, CO 81003	State	Psychiatric Hospital										
-Psychiatric Clients			289	652		26,668	24,832	1,326	50	460		
-Medical/Surgical service for non-psychiatric clients of other institutions			15			964	500	400		64		
Fort Logan Mental Health Center 3520 W. Oxford Denver, CO 80236	State	Psychiatric Hospital	41	109	92	8,989	5,441	625	741		2,182	

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SURVEY OF NEED

A. PROCEDURES FOR NEED SURVEY

1. Task Force

In December 1975, a Need Assessment Task Force was formed from the Statewide Evaluation Advisory Committee to assist the Division of Mental Health in planning and implementing a statewide Need Assessment Survey. The members were program evaluators from four community mental health centers and one state hospital, plus central office staff. Major emphasis was placed on designing a community survey with the purpose of identifying specific target groups. In addition, local experience with social indicator studies, including but not limited to the Mental Health Demographic Profile System (MHDPS), was reviewed.

2. MHDPS

Eleven socioeconomic/demographic variables were selected from those available in the MHDPS. Four of them were suggested by the federal guidelines for State Mental Health Plans, and the task force felt they were appropriate. These were population in poverty, males in low occupational status, overcrowded housing and recent movers. We also included two ethnic groups of particular concern in Colorado: Blacks and Chicanos.

Because we wanted a direct measure of the extent of the aged and youth in the catchment area populations, the actual percent of these two groups were substituted for the dependency ratios suggested by the guidelines.

An additional category called family disruption was included since it represents an important factor in the workload of all agencies in Colorado's system. Furthermore, this factor is a major source of stress

contributing to the likelihood of mental health problems. Three MHDPS variables were chosen: non husband-wife households, children not with both parents, and divorced/separated females.

3. Community Survey

Three groups of community informants were selected for a general, open-ended need assessment survey. The first group consisted of lay people representing major occupational types in a community such as store clerks, bartenders, housewives, student leaders, farmers or ranchers, etc. In the second group were the human service workers, such as judges, public health nurses, teachers, welfare workers, ministers, family physicians, etc. The third group was made up of people directly involved in mental health activities and included board chairmen, agency heads, and Mental Health Association officials.

The returns from the survey are still being received and the data analysis is not complete. Thus these data were not considered in the need assessment rankings; however, a report containing initial impressions is included in Section D. State Plan updates in the future will contain more data of this type.

B. NEED INDICATORS USED, DEFINITIONS, JUSTIFICATIONS, AND DATA SOURCE

Indicator	Definitions	Justification	Source
A. % population in poverty	Poverty - The Federal Gov't cutoff weighted by the Census Bureau by age, farm/nonfarm, size of family unit, and sex of head of household.	NIMH factor analysis indicator Reflects low economic status	MHDPS 1970
B. % males 16 yrs and older in low occupation status	Low Occ. Status - Those who are operatives, service workers, and laborers including farm laborers.	Shown by NIMH factor analysis to be one of best indicators of an area's demographic and social dimensions. Reflects low socio-economic status.	MHDPS 1970
C. % overcrowded housing	Percent household population in housing with 1.01 or more persons per room.	NIMH factor analysis indicator. Reflects stressful living condition due to overcrowding.	MHDPS 1970
D. non husband-wife households	Household - Includes all the persons who occupy a group of rooms or a single room which constitutes a separate living quarters. Husband-wife - Includes common-law as well as formal marriages.	NIMH factor analysis indicator. Reflects broken families	MHDPS 1970
E. % children not living with both parents	Includes stepchildren and adopted children as well as children born to a couple.	Reflection of broken homes and stressful conditions for children and remaining parent.	MHDPS 1970
F. % divorced/ separated females	Includes persons who are living apart because of marital discord, with or without a legal separation.	Reflection of one parent homes and stress of divorce	MHDPS 1970

Indicator	Definitions	Justification	Source
G. % of recent movers	Recent movers - Population who moved into present residence in 1969-1970.	NIMH factor analysis	MHDPS 1970
H.1 % Spanish heritage (Chicano)	Spanish heritage - Persons identified by: (1) having a Spanish surname when matched against a list of over 8000 names; or (2) the use of the Spanish language was reported.	Reflects stresses associated with minority group membership.	MHDPS 1970
H.2 % Black	Percent of household population that is Negro.	Same as above	MHDPS 1970
I. % Aged	Percent of population who are 65 and older.	Reflects a special target group	MHDPS
J. % Youth	Percent of population who are 16 and under.	NIMH factor analysis indicator. Reflects a special target group	MHDPS 1970

C. WEIGHTS FOR NEED ASSESSMENT FACTORS

Factor and items		Weight
Socioeconomic		5.00
Poverty	2.00	
Low occupational status	1.50	
Overcrowded living situtation	1.50	
Family disruption		3.00
Non husband-wife households	1.00	
Children not living with both parents	1.00	
Divorced/separated females	1.00	
Community change		0.75
Recent movers	0.75	
Spcial target groups		1.75
Chicanos, Blacks	.75	
Aged	0.50	
Youth	0.50	

One reason for having a public mental health system is to provide services for that segment of the population which cannot afford to buy professional help from private mental health practitioners. Furthermore, low socioeconomic status has been traditionally associated with mental health problems. Therefore, the greatest weight was assigned to the indicators of socioeconomic distress with the most direct measure, percent of population in poverty, receiving the most weight among the three items.

Family disruption and community change create stressful conditions which are frequently associated with the need for mental health services. Family disruption indicators were weighted slightly less than socioeconomic indicators since the latter represents two areas of need: distress due to social factors and lowered ability to pay for service. Our indicator of community change, percent of recent movers, is based on 1970 census data and while we know that certain areas of the State have experienced rapid growth which these data do not reflect, we are unable to accurately document it at this time. Therefore, the community change indicator was given a low weighting.

Three special target groups were identified: ethnic minorities, aged and youth. While many of the people in these groups are also in one or more of the other social indicator categories, they are given additional weight in the rankings because of their need for specialized programs. The ethnic minority item was given slightly more weight than the other two target groups because it represents a combination of Chicanos and Blacks. These were combined because the distribution of the Black population is concentrated in a few catchment areas which makes ranking across the State difficult.

D. PRELIMINARY IMPRESSIONS OF COMMUNITY SURVEY (HUMAN SERVICE AND LAY PEOPLE)

While the survey questionnaires are still being returned and the formal analyses have not begun, some initial impressions can be reported. Loneliness, fear, and poor communication between parents and children and between husband and wife are common themes. Many target groups are mentioned but several are especially noteworthy because they are so consistently mentioned.

1. Divorce/broken families - the effect on children and parents, especially mothers who must take on major new responsibilities.
2. Alcoholism and other drugs - teenagers are frequently mentioned as alcoholism becomes an increasingly prevalent problem for youth.
3. Elderly - insufficient resources both in terms of money and accessible activities.
4. Welfare mothers - poor self regard and the very real problems of managing limited funds.

The response has been extremely encouraging. Even a casual reading of the forms leaves the impression that the writers gave serious thought to the mental health problems in their community before they responded. Several thanked us for the opportunity to participate, and a surprising number signed their names. Not as surprising is the 2-1 ratio of human service to lay respondents. We had hoped for a 15-20% return rate and it now stands at 17%.

REGION	COMMUNITY AGENCY	SOCIOECONOMIC INDICATORS						FAMILY DISRUPTION						CHANGE		SPECIAL TARGET GROUPS								FINAL RANKS (K)**
		POP. in POVERTY (A)		LOW OCCU. STATUS MALES (B)		OVERCROWD HSEHOLDS (C)		HSEHOLDS NOT HUS-HIFE (D)		CHILDREN NOT WITH BOTH PAR. (E)		DIVORCED OR SEP. FEMALES (F)		RECENT MOVERS (G)		CHICANO	BLACK	TOTAL*	(H)	AGED (I)		YOUTH (J)		
		%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	%	%	RANK	%	RANK	%	RANK	
1	NE Colorado	17	7	34	11.5	16	10.5	27	12	11	18	3	20.5	25	17	7	-	7	16	12	4	35	13	12
2a	Weld	17	7	38	6.5	19	6.5	26	15	13	13	4	16.5	34	6.5	15	-	16*	8.5	8	14	35	13	9
2b	Larimer	14	11.5	30	14.5	11	15.5	29	8.5	12	15	4	16.5	40	2.5	7	-	7	16	9	12.5	30	18	14
3a	Adams	7	16.5	37	8	16	10.5	16	21	12	16	5	11.5	26	15	15	1	16	8.5	3	21	45	1	13
3b	Arapahoe	6	19.5	23	19.5	8	19.5	21	18	11	18	6	7.5	27	12.5	5	-	5	18.5	5	18	40	3	20
3c	Boulder	10	14.5	26	17.5	9	17.5	30	6	11	18	5	11.5	39	4	6	1	7	16	7	15	33	17	17
3d	Jeffco	6	19.5	23	19.5	8	19.5	20	19.5	10	20.5	6	7.5	27	12.5	4	-	4	20.5	5	18	38	5	21
3e	Bethesda	7	16.5	20	21	5	21	34	3	14	11	7	4	29	9.5	4	-	5*	18.5	11	7.5	29	19.5	18
3f	NW Denver	24	2	45	1	18	8	56	1	34	1	13	1	36	5	30	10	40	2	14	1	28	21	1
3g	Malcolm X	10	14.5	30	14.5	11	15.5	43	2	23	2	9	2	34	6.5	9	24	33	4	11	7.5	29	19.5	8
3h	SW Denver	6	19.5	34	11.5	14	13	20	19.5	14	11	7	4	21	20	18	-	18	6.5	5	18	38	6	15
3i	Aurora	6	19.5	26	17.5	9	17.5	26	15	15	8.5	7	4	40	2.5	6	1	8*	13.5	4	20	36	9	16
4	Pikes Peak	12	13	29	16	13	14	26	15	16	6	6	7.5	45	1	8	5	14*	10	6	16	35	13	11
5	E Central	16	9	31	13	15	12	25	17	10	20.5	3	20.5	22	19	4	-	4	20.5	12	4	36	9	19
6	SE Colorado	23	3	39	5	22	4	30	6	16	6	4	16.5	24	18	22	-	22	5	12	4	38	5	4
7	Span Peaks	17	7	41	3.5	24	3	31	4	18	3.5	6	7.5	20	21	34	2	36	3	10	10	36	9	3
8	San Luis	29	1	41	3.5	31	1	27	12	16	6	4	16.5	26	16	46	-	46	1	10	10	41	2	2
9	SW Colorado	10	5	35	10	25	.2	27	12	18	3.5	5	11.5	28	11	18	-	18	6.5	9	12.5	37	7	5
10	Midwestern	20	4	38	6.5	20	5	28	10	14	11	4	16.5	29	9.5	10	-	10	12	12	4	35	13	6
11,12	Colorado W	14	11.6	36	9	17	9	29	8.5	15	8.5	5	11.5	32	8	8	-	8	13.5	10	10	35	13	10
13	W Central	16	10	44	2	19	6.5	30	6	12	15	4	16.5	26	15	12	1	13	11	12	4	34	16	7

*The total percent does not equal the sum of the Chicano and Black percents due to rounding.
**Derived as follows using the rank values in each column, K = 2(A) + 1.5(B+C) + (D+E+F) + 0.75(G+H) + 0.5(I+J)

DEPARTMENT OF INSTITUTIONS
RAYMOND LEIDIG, M.D., Executive Director
DIVISION OF MENTAL HEALTH
James R. Dolby, Ph.D., Director
4150 South Lowell Boulevard
Denver, Colorado 80236
Telephone: (303) 761-0220

RICHARD D. LAMM
GOVERNOR

June 29, 1977

M E M O R A N D U M

TO: Board Presidents and Executive Directors of Mental Health Centers & Clinics
Superintendent, Colorado State Hospital
Director, Fort Logan Mental Health Center

FROM: Youlon D. Savage, ACSW
Deputy Director

SUBJECT: Advance Copy of 1977-78 Supplement ot the Colorado Mental Health Plan

This memorandum accompanies advance copies of the 77-78 Supplement to the State Mental Health Plan. As was the case with the basic Plan, this document reflects the recommendations and comments of numerous agencies, organizations and individuals. As indicated on the cover, the Supplement is not complete unto itself, but must be used along with the basic Plan.

The State Mental Health Plan, unlike many other "master plans" is a functional, dynamic statement of policy. It is also a manual which explicates the what, the why and the how. The State Plan has been, and will continue to be the basic document used in preparation of the Division of Mental Health's budget requests.

It is recommended that some board, staff and volunteer training sessions be developed around the Plan, and that the Plan, or portions of it, be reproduced as necessary to ensure that is is readily available for general use.

In respect to implementation, your attention is invited to Chapter III, the goals and objectives. Centers and clinics should take special note of the requirements for plans for services to children, adolescents, the elderly and chronically disabled, high-risk persons. The development of the required plans is not only essential to the accomplishment of the goals and objectives, but is necessary to satisfy one condition of the contract between each center/clinic and the Division of Mental Health.

Please contact your Program Specialist or me if you have questions concerning the Plan.

YDS:so
Enclosure
cc: J. Dolby
R. Leidig
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Charlotte Redden
Karen Litz
Elinor Stead
Board Contact Person
Staff - DMH

1977-78 SUPPLEMENT
TO THE
COLORADO MENTAL HEALTH PLAN

A plan based on use of the least restrictive alternative in the treatment of the mentally disabled.

(This Supplement is not complete unto itself, but must be used in conjunction with the State Mental Health Plan dated August 1976.)

PREPARED BY
COLORADO DIVISION OF MENTAL HEALTH

James R. Dolby, Ph.D.
Director

June 1977

1977-78 SUPPLEMENT
TO THE
COLORADO MENTAL HEALTH PLAN

INDEX

CHAPTER I

INTRODUCTION

1977-78 SUPPLEMENT TO THE COLORADO MENTAL HEALTH PLAN

I. INTRODUCTION

A. PURPOSE

The purpose of this supplement is to update the State Five Year Mental Health Plan. The annual updating of the Plan is necessary to reflect the impact of funding and policy decisions by legislative and executive bodies and the accomplishment or non-accomplishment of the previous year's objectives. Changes in roles and relationships among agencies, organizational and structural changes, the enactment of new statutes and the amendment or repeal of existing statutes also make necessary a periodic updating process. The publication of rules and standards for the implementation of statutes or the regulation of mental health related activities affect the planning and delivery of mental health services to such an extent that they must be incorporated into the Plan. Changes in priorities, and the results of research and pilot projects have little meaning unless they are appropriately and currently recorded in the State Plan, which is the written record of the planning process.

B. ORGANIZATION AND SCOPE

The 77-78 Supplement does not alter the thrust of the Plan; viz, the provision of high quality mental health services close to the home of the client and in the least restrictive setting. Also, the principles set forth in Chapter I of the basic document remain in effect. These principles, which embody the philosophy of the Division of Mental Health, are summarized under the following four headings: human dignity, privacy and client's rights; least restrictive setting; availability of services close to home; and funding and accountability.

The Supplement is to be used in conjunction with the basic document; thus, no attempt has been made to repeat the parts of the Plan which are not begin superceded or altered, unless the readability of sentences, paragraphs or pages of the Supplement will be enhanced by repeating some material.

New and revised material is organized in a manner which will facilitate cross-reference with the appropriate chapter, section, page and paragraph in the basic document.

A summary of the major changes in each chapter follows:

CHAPTER I - INTRODUCTION

The process by which the Plan was updated is included in the initial chapter to indicate to the reader the Division's efforts to obtain input from as many sources as possible and the mechanism for ensuring careful review of all suggestions for updating the Plan.

CHAPTER II - ADMINISTRATIVE INFORMATION

The State Mental Health Advisory Council has become operational since the basic Plan was published. A brief description of the activities of the Council, including its participation in the review process, is included in this chapter. The updated Division of Mental Health organizational chart also will be found in Chapter II of this Supplement.

CHAPTER III - STATEWIDE GOALS AND OBJECTIVES

The objectives have been completely revised. New objectives have replaced those that have been accomplished, the target dates for some have been made more realistic, and others have been rewritten to indicate more clearly what is to be achieved.

An important change in the objectives is the requirement that each catchment area center/clinic develop a plan for increasing services to children, adolescents, the elderly and chronically disabled persons. The previous approach was to require all agencies to achieve the same fixed percentage increase in services, or to tie the percentage of each target group served to its percentage in the general population. The new approach recognizes that local needs, problems and resources differ from community to community. The process in each catchment area will involve (1) determining service needs of children, adolescents, the elderly, and the chronically disabled and other groups; (2) developing an inventory of resources (services, facilities, funds) available to meet the identified needs; (3) identification of gaps in service; (4) setting priorities; (5) developing a plan for, and providing services with existing resources; (6) evaluation of success in achieving the objectives; and (7) longer range program and fiscal planning. The planning process must also provide for input from local citizens, other service and planning agencies, client advocacy groups and elected representatives.

- I.3 -

This chapter continues to be the "heart" of the Plan as it translates into specific planned actions the purpose, philosophy and thrust of the state mental health system.

CHAPTER IV - THE STATE MENTAL HEALTH PROGRAM

Chapter IV of the Supplement basically updates the descriptive information in the basic document. Important changes in funding of substance abuse services at the state hospitals are reported as are the reorganization of Fort Logan Mental Health Center and the publication of the Standards/Rules and Regulations for Mental Health Centers and Clinics. Statements concerning fiscal support of mental health services and the requirement for volunteer services have also been added.

CHAPTER V - COORDINATION OF PLANNING

The State Mental Health Plan must be carefully integrated with the State Health Plan, the Alcohol and Drug Abuse Plan and the planning process and documents of many other agencies and organizations. Chapter V is a current statement of the changes in the relationships, roles and structures of the various agencies with which the DMH interfaces in the planning and/or delivery of mental health services. A summary of the status of the health planning apparatus mandated by PL 93-641 (the National Health Planning and Resource Development Act) is an important part of the updated material.

CHAPTER VI - CATCHMENT AREA MENTAL HEALTH PROGRAM

This chapter reflects a number of changes in the services available in some catchment areas, and the rankings (based on indicators of need) of catchment area community mental health centers and clinics. The revised population figures and the ethnic composition of each catchment area are also included.

APPENDIX

The appendix of the 77-78 Supplement includes a number of documents not found in the basic Plan. These are:

(1) Standards/Rules and Regulations for Mental Health Centers and Clinics (not included in all copies of the Plan, as the document has already been widely distributed);

(2) Rules and Regulations for the Care and Treatment of the Mentally Ill;

(3) Standards for Mental Health Care in Health Care Facilities;
(4) Availability of Comprehensive Community Mental Health Services in the 21 Catchment Areas (per PL 94-63);
(5) minutes of the State Mental Health Advisory Council meetings;
(6) Bylaws of the State Mental Health Advisory Council;
(7) the roster of the State Mental Health Advisory Council;
(8) Report of Accomplishment of Objectives in 76-77 State Mental Health Plan.

A current report from the Chicano Mental Health Symposium is also available in the appendix.

C. PROCESS BY WHICH THE SUPPLEMENT TO THE STATE MENTAL HEALTH PLAN WAS PREPARED

This Supplement is the result of the first annual review of the State Mental Health Plan. The process followed in the development of this update for fiscal year 77-78 was as follows:

1. In November 1976, a notice of the coming review of the Plan was sent to all agencies and organizations on the regular distribution list. Those wishing to make input into the Supplement were asked to submit their recommendations and suggestions by January 31, 1977.
2. Members of the State Mental Health Advisory Council were asked to assist the State Mental Health Plan Committee in reviewing the input from various agencies and organizations and drafting some recommended changes.
3. The State Mental Health Plan Committee was reconvened. The process to be followed in the updating was discussed, and Committee members were assigned the responsibility for reviewing the input on various sections and chapters of the Plan, and, in collaboration with the agencies and organizations they represent, draft proposed changes and new material for the Supplement.
4. The Division of Mental Health staff were asked to review the input from various agencies and organizations along with the basic document and draft recommended changes in their individual specialty areas. Staff were asked to collaborate with State Mental Health Advisory Council and State Mental Health Plan Committee persons wherever possible.

5. A draft of the supplement was forwarded to ADAMHA and to the agencies and organizations on the mailing list for review and comment.
6. The draft was reviewed by the State Mental Health Advisory Council, with particular attention to the objectives. Representatives from private, voluntary, and other community agencies participated in the discussion of the draft and offered suggestions concerning various sections of the documents.
7. The A-95 review process was initiated.
8. Preparation of the Supplement, incorporating appropriate suggestions from the various agencies and organizations and other reviewers, was accomplished.
9. The Supplement was submitted to the Region VIII ADAMHA Office.

CHAPTER II

ADMINISTRATIVE INFORMATION

II. ADMINISTRATIVE INFORMATION

B. STATE MENTAL HEALTH ADVISORY COUNCIL

1. Membership

The State Mental Health Advisory Council (SMHAC) was appointed in September 1976 by Governor Richard Lamm. The Council consists of 21 members. The roster of Council members with information as to sex, ethnic background, place of residence, class of membership and expiration of term is included in the appendix.

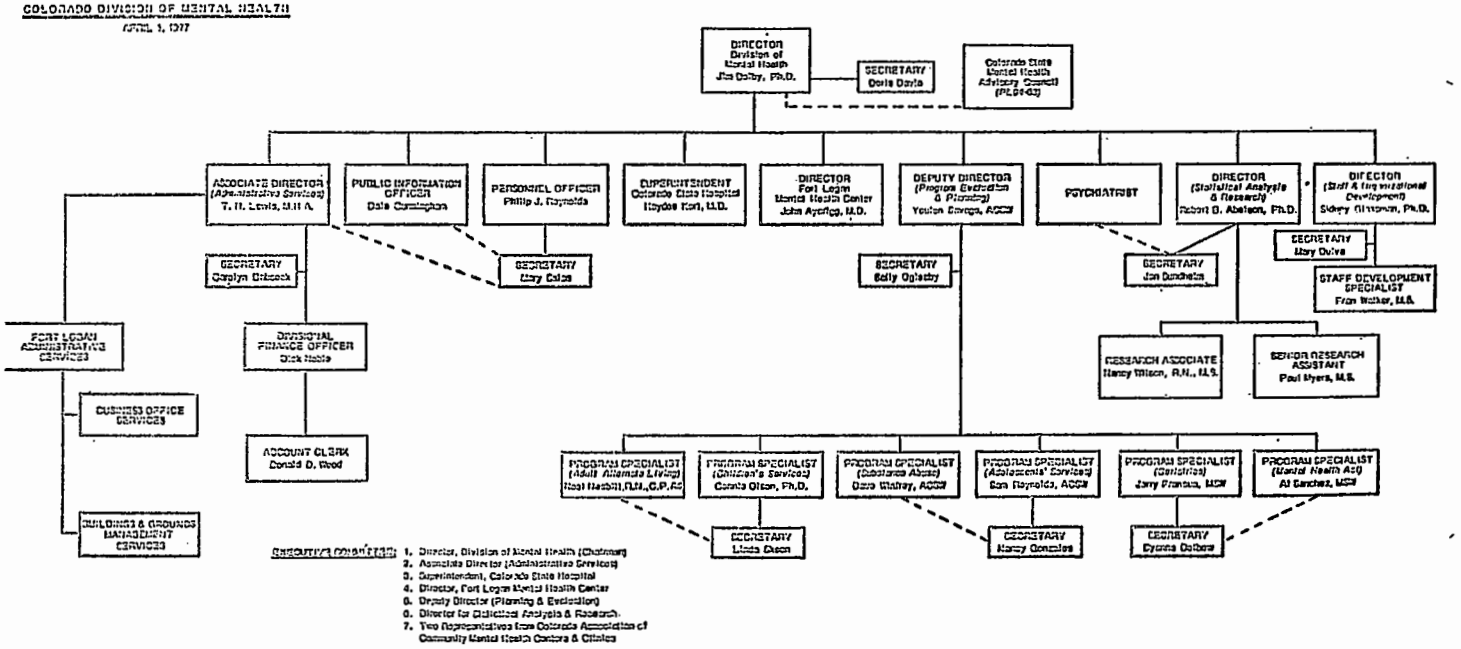
2. Activities of the SMHAC

The SMHAC has met monthly since its formation. Minutes have been kept of all meetings (a copy of the minutes of each meeting is included in the appendix). The activities of the Council to date have included the election of officers, the development of bylaws (a copy of the bylaws is included in the appendix) and review of the State Plan. Council members have also appointed two permanent subcommittees, the Executive and Budget Subcommittees, and several ad hoc committees including one on children/adolescent services and one to review the interface between mental health and substance abuse services, with a view toward improving the integration of services.

The Council has begun hearing presentations by various DMH staff specialists to gain a better understanding of the functions of the mental health system and how the various staff activities relate to the State Plan. SMHAC gave special attention to a legislatively mandated study of placement facilities for disturbed children, and requested and received a presentation from the Colorado Association of Community Mental Health Centers and Clinics. The Budget Subcommittee participated in a detailed review of the Division's recommendations for funding, following which the Council directed letters to the Governor and the Joint Budget Committee of the State Legislature concerning the funding needed for mental health services.

Council members reviewed the suggestions received from various agencies and organizations concerning the update of the State Plan. The draft of the update material was carefully studied with particular attention to the various target groups identified in the Plan.

DIVISION OF MENTAL HEALTH
ORGANIZATIONAL CHART



CHAPTER III

STATEWIDE GOALS AND OBJECTIVES

III. STATEWIDE GOALS AND OBJECTIVES

A. GOALS

One purpose of the planning process is to develop procedures and mechanisms for managing the activities, tasks, and changes necessary to accomplish the mission and purpose of the organization. The setting of goals is both an essential element of the planning process and an important product. The goals in this chapter provide direction to the efforts of the public mental health system. The objectives which follow serve the dual functions of describing the steps necessary to accomplish the goals, and providing a means of assessing progress. These goals and objectives are to be our guidelines; however, they will be responsive to changing needs and other factors that evolve during the continuous planning process.

Woven into the fabric of the goals are the principles which undergird the state public mental health delivery system. These principles emphasize the provision of cost-effective services close to home, in the least restrictive setting, and in a manner which preserves human dignity, privacy and rights. The goals and objectives are the heart of the plan and serve as a unifying force which pulls together the various elements of the plan. These elements include need, special target populations, available and needed resources, coordination with other caregivers, the roles of the various components of the system, administration and accountability, and as previously indicated, the principles underlying the delivery of mental health services.

The goals and objectives are also in congruence with the congressional intent embodied in Public Law 94-63, the Community Mental Health Centers Amendments of 1975. This act focuses on: (1) the availability of a full range of mental health services (inpatient, partial hospitalization, outpatient, 24-hour emergency and consultation and education) in local communities; (2) special efforts to meet the mental health service needs of children, the aged, rape victims, and substance abusers; (3) preadmission screening to reduce inpatient care; (4) the development of halfway houses and other alternatives to inpatient care; (5) follow-up care for persons who have been discharged from a mental health facility; and (6) services directed towards the prevention of mental illness.

The goals in the 77-78 Supplement are the same as those in the basic State Mental Health Plan, with the exception that "high-risk" replaces "chronically disabled" in Goal #3. The high-risk category includes the chronically disabled in all age groups who are receiving or who require inpatient, other 24-hour, partial, or intensive outpatient care. Since there are specific objectives relating to each age group, the objectives for the high-risk category are primarily focused on former state hospital clients who require ongoing care, and other chronically psychiatrically disabled persons.

For the purpose of this document, ethnic minorities are: Asians (including Pacific Islanders), Blacks, Chicanos and Native Americans.

Quarterly reports on the fiscal year 76-77 objectives are included in the appendix to facilitate a review of the system's successes and failures. Some failures are attributable to faulty formulation of objectives; others are the results of organizational changes, the lack of adequate funding, the absence of systemwide commitment to serve the target populations, and failure to take into consideration the great diversity among catchment areas as to local needs, available resources and priorities.

The objectives in the Plan are product, rather than process oriented. In those instances where the objectives require meetings, conferences and joint activities between elements of the public mental health system and other agencies and organizations, the product will be the progress made toward resolution of the problems identified in Chapter V, as well as other current interagency problems.

It is not expected that each mental health center/clinic and hospital will become the sole provider of the myraid of mental health and related services which should be available in all catchment areas. However, mental health agencies are expected to mobilize, and facilitate the use by clients of the various community resources available. These resources include a variety of alternate living facilities, health agencies, social service programs and other caregivers, activities and organizations in the public, private and voluntary sectors. Affiliation and contractual arrangements between mental health and other agencies are strongly encouraged.

The availability of adequate funding is a crucial variable in the accomplishment of the objectives in this Plan. In this connection, it

is of concern that federal funding for the maintenance of existing programs is declining and income from the state and local governments and other funding sources is not sufficient to support, on an ongoing basis, programs initiated with federal funds. These fiscal problems are further aggravated by general inflationary trends.

With service demands staying well ahead of dollar resources, increasing emphasis must be placed on full utilization of other community resources as indicated above, and re-examination of needs and priorities at the local and state levels to ensure that available dollars are used in the areas of greatest service need. Scaling down of the anticipated outcome of some objectives, and extending the timetable for the accomplishment of other objectives are viable options that must be considered.

The following comprehensive goals are interrelated and interdependent; therefore, the order of listing does not indicate relative priority.

1. Goal #1

To provide mental health services through a system which:
- is cost-effective
- is coordinated with other agencies
- is efficient
- is based on the assessment of mental health needs
- establishes and enforces quality of care standards
- is evaluated.

The delivery of mental health services must be based on sound management principles which include determining what the needs are, obtaining the resources to meet these needs, providing effective services in the most efficient manner and evaluating the impact of the services. Also necessary to this process are coordination with other agencies and the existence and enforcement of standards.

2. Goal #2

> To provide mental health services to the citizens of Colorado, emphasizing services which are:
> - least restrictive
> - community based
> - comprehensive
> - close to home
> - integrated
> - appropriate

The intent behind this goal is to provide services as close as possible to the client's home, in the most normal or home-like setting possible, and to emphasize utilization of the least intensive service consistent with the treatment needs of the client. The accomplishment of this goal requires:

a. recognition of the catchment area centers/clinics as the primary point of entry for clients entering the public mental health system;

b. preadmission screening to insure that clients are not admitted to inpatient or another more intensive level of care than is required to effectively and efficiently treat them;

c. the development in each catchment area of the array of mental health services necessary to meet the service needs of the residents, including a range of alternatives to inpatient care for those clients who require 24-hour care, but not inpatient hospitalization;

d. the use of Fort Logan (the state hospital serving the Denver metropolitan area) for short-term inpatient hospitalization of adults from the metropolitan Denver area in those instances where the cost of care in a general or psychiatric hospital is not competitive with the cost at Fort Logan;

e. the use of state hospitals for inpatient care for specialized inpatient services to children, adolescents and the aged who specifically require inpatient hospitalization;

f. the use of state hospitals and appropriate center/clinic services for clients requiring long-term care; (This will obviously require the development of criteria to be used as the basis for selection

of the appropriate treatment setting, and the movement of a client from one setting to another.)

g. the sharing of services among or between contiguous catchment area centers/clinics;

h. the provision of services through contractual or other formal arrangements with other local public, voluntary or private resources;

i. the continued use of Colorado State Hospital for the provision of adult inpatient services to the Pueblo area;

j. prior determination of the short-term adult inpatient average daily attendance for Fort Logan Mental Health Center and Colorado State Hospital to insure proper staffing of the treatment units.

In summary, this goal emphasizes the intent that the basic responsibility for the provision of mental health services rests with catchment area centers/clinics. Services will be provided in the local community whenever practicable. Inpatient services will be used only for those clients for whom inpatient services are clearly indicated.

Alternate treatment facilities, including skilled nursing homes, intermediate care facilities, residential care facilities, halfway houses, family care homes, and foster homes will be developed in the various catchment areas. The availability of these facilities and pre-admission screening are expected to reduce the inappropriate use of inpatient beds.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:	
- children	- ethnic minorities
- adolescents	- rural residents
- elderly	- economically disadvantaged persons
- alcohol and drug abusers	- women
- rape/sexual abuse victims	- high risk persons

The indicated groups have been targeted because of the need for specific programs to meet their unique mental health needs. Utilization

reports indicate that children and adolescents and the elderly are underserved. Chicanos, the largest ethinc minority group in Colorado, require a range of services which take into consideration not only the cultural factors which affect all Chicanos, but the diversity of mental health needs within the Chicano population.

Appendix II is the report of the Chicano Mental Health Planning Symposium, which took place in Denver in January 1976. This report identifies a number of issues essential to the planning and delivery of mental health services to Chicanos. Many of the symposium recommendations are incorporated in this plan.

Other ethnic minority groups, while comparatively small in number, also have a right to expect some attention to be directed to the impact of their cultural heritage on their mental health service needs. Rape/sexual abuse victims, rural residents and women can be better helped in treatment programs which are sensitive to their unique needs. The poor, which are also represented in some of the other groups, are the highest users of public mental health services. Treatment programs which can identify their special needs and ways of addressing these needs are essential.

An almost neglected target population is the chronically disabled, many of whom are former state hospital inpatients. The intent is to insure that the chronically disabled are identified and provided the services necessary to improve their overall functioning to the fullest extent possible, and that every effort is expended to avoid hospitalization or re-hospitalization unless such care is specifically required.

4. Goal #4

> To increase public knowledge of mental health services and ways of preventing mental illness.

Preventive services are directed at the many potential victims of mental illness, i.e., that segment of the population which, while not visibly mentally ill, function below their potential capacities. The primary thrust of this goal is the promotion of mental health by helping people acquire knowledge, attitudes, and patterns of behavior which will foster and maintain their mental well-being. Prevention-oriented mental health education must take into account the make-up of the individual

communities to be served, i.e., the proportion of aged, ethnic minorities, children, etc., and the most effective ways of reaching these groups. In this connection, there is considerable evidence to support the contention that a prevention program based on the individual, family and small group contacts, is an effective strategy to employ in the provision of services to Chicanos. This application of the prevention concept may, for many Chicanos, be more beneficial than traditional direct service methods. A major concern to be addressed is the lack of data on the impact of preventive programs.

5. Goal #5

> To increase consultation services to other public agencies that provide services to mentally ill persons.

The term consultation services, as used in this plan, applies primarily to assisting other community service professionals improve their skills in working with mentally ill persons. Community service professionals to whom consultation services are offered include school personnel, law enforcement officials, social service workers, court personnel, public health nurses, agricultural extension workers, clergymen, physicians, and others. These individuals are the "gate-keepers" of the mental health system, for in times of trouble they are the ones to whom the average person turns for help, and they account for the largest percentage of referrals to mental health service agencies. Obviously, the more skilled the "gate-keepers" are, the more effective they will be in early detection and early intervention. Possible outcomes of the involvement of skilled "gate-keepers" include the prevention of some serious mental health problems and more appropriate referrals to mental health centers/clinics and hospitals.

B. OBJECTIVES

1. Goal #1

To provide mental health services through a system which:
- is cost-effective
- is coordinated with other agencies
- is efficient
- is based on the assessment of mental health needs
- establishes and enforces quality of care standards
- is evaluated

a. Cost-Finding System:

(1) By July 1, 1978, comparable cost-finding data will be available for all centers/clinics.

(2) By July 1, 1978, DMH will develop a model uniform chart of accounts for centers/clinics.

(3) By July 1, 1978, DMH will develop a comprehensive uniform management reporting system for the two state hospitals.

(4) By July 1, 1978, DMH will develop and implement a prospective unit reimbursement mechanism for centers/clinics.

(5) By July 1, 1978, DMH will have determined the estimated cost of implementation of the State Mental Health Plan.

(6) By January 1, 1979, the financial reporting systems for centers/clinics and the two state hospitals will be comparable.

b. Audit Guidelines:

(1) By October 1, 1977, the initial audit of all centers/clinics based on the financial audit guidelines will be completed.

c. Energy Conservation:

(1) By July 1, 1979, a total energy conservation study will be done at both state hospitals.

(2) By July 1, 1979, the two state hospitals will begin a planned and orderly retrofitting of buildings and heating/cooling systems to maximize energy conservation. This will include insulation programs, storm windows, caulking of buildings, changing fixed windows to moveable, installing 24-hour automatic controls on heating/cooling/ventilating systems.

(3) By July 1, 1981, state hospitals will begin conversion to solar heating/cooling, if proven feasible by the energy conservation study.

d. Staffing Pattern:

(1) By January 1, 1978, DMH will recommend hospital staffing patterns based on SCOPE/COLO '77 for legislative consideration.

(2) By July 1, 1978, the recommended staffing patterns for the state hospitals will be based on management engineering principles and normative standards.

(3) By July 1, 1978, a summary of the salary and classification survey will be made available to all mental health centers/ clinics.

(4) By July 1, 1978, the annual update of the personnel needs and resources of the mental health system will be accomplished.

e. Treatment Outcome Evaluation:

(1) By December 1, 1977, a statewide plan for treatment outcome evaluation will be designed.

(2) By December 1, 1977, a pilot to test possible methodological approaches to be incorporated into this plan will be completed.

(3) By July 1, 1978, DMH will be ready to implement a data collection system on treatment outcome evaluation.

f. Coordination With Other Agencies: (See Chapter V for discussion of interrelationships and issues involved in these meetings.)

(1) By October 1, 1977, the State Mental Health Advisory Council will have established a mechanism to secure input concerning the State Plan and the entire mental health system from the various private/voluntary agencies that are involved in mental health care.

(2) By January 1, 1977, the DMH will facilitate a series of meetings between mental health agencies and agencies and organizations concerned with services to developmentally disabled clients.

(3) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the State Health Planning and Development Agency.

(4) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with Colorado Psychiatric Hospital.

(5) By July 1, 1978, DMH will have had at least four meetings (since July 1, 1977) with divisions of the Department of Social Services.

(6) By July 1, 1978, DMH will have had one meeting (since July 1, 1977) with the State Health Coordinating Council.

(7) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the Department of Education.

(8) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the Judicial Department.

(9) By July 1, 1978, DMH will have had at least four meetings (since July 1, 1977) with units of the Department of Health.

g. Need Assessment:

(1) By January 1, 1978, a comprehensive inventory of specialized services for ethnic minorities offered by state hospitals and mental health centers/clinics will be produced.

(2) By March 1, 1978, an annual inventory of existing facilities will be performed.

(3) By July 1, 1978, the preliminary need assessment data on high-risk populations will be further refined and expanded.

h. Standards and Evaluation:

(1) By July 1, 1978, the first review and update of the revised State Standards/Rules and Regulations for Mental Health Centers and Clinics will be accomplished.

(2) By July 1, 1978, each mental health center/clinic will have been evaluated using the new on-site evaluation instrument to lead to approval for purchase of services for a one-year period.

(3) By July 1, 1981, the State Standards/Rules and Regulations for Mental Health Centers and Clinics will be completely revised.

i. Management Information System Master Plan:

(1) By July 1, 1978, the MIS Master Plan will be developed.

j. Volunteer Services:

(1) By November 1, 1977, all centers and clinics will have a documented orientation and training program for volunteers.

(2) By January 1, 1978, all centers and clinics will have an identifiable volunteer service.

(3) By January 1, 1978, DMH will develop, in collaboration with the ADAMHA coordinator of volunteer services and the coordinators of

volunteer services in centers/clinics and hospitals, a mechanism for the exchange of information and input into the program planning process.

(4) By June 30, 1978, guidelines will have been developed for volunteer services in mental health centers/clinics and hospitals.

2. Goal #2

To provide mental health services to the citizens of Colorado, emphasizing services which are:
- least restrictive
- community based
- comprehensive
- close to home
- integrated
- appropriate

a. Use of Hospitalization:

(1) By July 1, 1978, the combined average daily attendance (ADA) at the two state hospitals will be stabilized at the FY 75-76 level.

(2) By July 1, 1978, Fort Logan Mental Health Center will be established as a primary agency for the provision of adult inpatient services to the Denver metro area.

(3) By July 1, 1978, there will have been a 6% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the state hospitals.

(4) By July 1, 1979, there will have been an 18% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the two state hospitals.

(5) By July 1, 1981, there will have been a 24% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the two state hospitals.

b. Center/Clinic-Hospital Integration:

(1) By July 1, 1978, guidelines recommended by Continuity of Care Committees and approved by DMH will be fully operational.

c. Services Close to Home:

(1) By March 1, 1978, DMH will have developed a management plan which will specify, by catchment area, the residential treatment alternatives required.

(2) By July 1, 1978, all centers/clinics will provide follow-up treatment services to persons discharged from inpatient care who require such services.

(3) By July 1, 1979, guidelines for alternate treatment facilities not covered by existing standards will have been developed and implemented.

(4) By July 1, 1979, all catchment areas will have 24-hour emergency care available.

(5) By July 1, 1981, the four catchment area clinics (Southeastern Colorado, Southwest Colorado, East Central and Northeast Colorado) will be comprehensive centers offering the five services. These services will be furnished directly or through affiliate agencies.

d. Continuing Education:

(1) By October 1, 1977, a training program for the training of house parents to work in youth group homes will be developed.

(2) By April 1, 1978, DMH will have developed training program models for increasing staff sensitivity to ethnic minority mental health needs and ways of meeting these needs.

(3) By July 1, 1978, the DMH will conduct at least one minority awareness training program.

(4) By July 1, 1978, the DMH will facilitate and/or provide training programs in support of the implementation of services mandated by PL 94-63.

(5) By July 1, 1978, the DMH, with the assistance of the Continuing Education Committee, will review and update the Standards for Continuing Education.

(6) By July 1, 1978, the Staff Development Section of the DMH will review and update training resource inventories for dissemination.

(7) By July 1, 1978, the Staff Development Section of the DMH will collect and disseminate information on the various licensure and continuing education requirements of mental health professions.

(8) By July 1, 1978, the Staff Development Section of the DMH will disseminate information regarding the collections of specialized educational materials within mental health resource centers.

(9) By July 1, 1978, the DMH will provide at least one workshop for business managers and finance staff of centers and clinics in the use of Division Accounting and Auditing Guidelines and related unit cost reimbursement system.

(10) By July 1, 1978, the DMH will provide at least one workshop for center directors in the use of Division Accounting and Auditing Guidelines and related unit cost reimbursement system.

(11) By July 1, 1978, the Division will have sponsored a training program for persons who work with the chronically disabled.

(12) By July 1, 1978, the Division will have made available to each center/clinic a minimum of two board training sessions (baseline July 1, 1976).

(13) By July 1, 1979, the DMH, with the assistance of the Continuing Education Committee, will develop a proposal for the funding of the training needs of the centers/clinics and hospitals.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:
- children
- adolescents
- elderly
- alcohol and drug abusers
- rape/sexual abuse victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- high risk persons

a. Children (Ages 0-11 years):

(1) By October 1, 1977, each center/clinic will submit a plan to DMH for services to children which must be approved by DMH in accordance with the annual contract.

(2) By October 1, 1977, educational and experiential standards for child clinical staff will be developed by DMH.

(3) By January 1, 1978, at least one clinician, trained in mental health evaluation and treatment of children and their parents, shall be providing and coordinating such services at each mental health center/clinic and shall meet the standards developed by DMH regarding adequacy of training.

(4) By January 1, 1978, an identifiable children's evaluation and treatment program shall be established in each mental health center/clinic, with a program description, goals and objectives being submitted to DMH, to include written agreements as to the relationship with and involvement in local schools, social services (with special attention to child abuse and neglect), the juvenile justice system and public health agencies.

(5) By July 1, 1978, the first annual review shall be conducted by both state hospitals in cooperation with appropriate mental health centers/clinics and DMH, to determine the size and types of programs each hospital needs to provide for children within each hospital service area.

(6) By July 1, 1978, the child program of each center/clinic will be mutually agreed upon between that center/clinic and DMH.

(7) By July 1, 1978, DMH will have worked jointly with other appropriate state agencies and organizations to attempt to develop a common classification system for problems and behaviors of troubled children, as well as a system to classify all facilities (public and private) which provide 24-hour care for such children in the state.

(8) By October 1, 1978, each mental health center/clinic shall have written agreements with local school administrative units as to the provision of mental health services to mentally and physically handicapped children, in compliance with PL 94-142 (Education of the Handicapped Act).

(9) By July 1, 1979, each child program shall have been evaluated during the annual site visit, according to the Standards/Rules and Regulations for Mental Health Centers and Clinics, and the goals and objectives set forth by each center/clinic.

(10) By July 1, 1979, DMH shall have worked jointly with other appropriate state agencies and organizations toward the development of standards for mental health services in all 24-hour programs for children not currently under the jurisdiction of the Department of Institutions or their parents.

(11) By July 1, 1979, each catchment area mental health center/clinic will provide mental health services to children requiring partial and 24-hour care, whether or not the facilities therefor are operated by the mental health center/clinic or by another agency or organization. Where such facilities are operated by another agency or organization, there must be a written agreement as to how the center/clinic shall provide mental health services to the facility.

b. Adolescents (Ages 12-17 years):

(1) By October 1, 1977, each center/clinic will submit a plan to DMH for services to adolescents, which must be approved by DMH in accordance with the annual contract.

(2) By October 1, 1977, educational and experiential standards for adolescent clinical staff will be developed by DMH.

(3) By January 1, 1978, at least one clinician, trained in mental health evaluation and treatment of adolescents and their parents, shall be providing and coordinating such services at each mental health center/clinic and shall meet the standards developed by DMH regarding adequacy of training.

(4) By January 1, 1978, an identifiable adolescents' evaluation and treatment program shall be established in each mental health center/clinic, with a program description, goals and objectives being submitted to DMH, to include written agreements as to the relationship with and involvement in local schools, social services (with special attention to adolescent abuse and neglect and teenage pregnancies), the juvenile justice system and public health agencies.

(5) By July 1, 1978, the first annual review shall be conducted by both state hospitals in cooperation with appropriate mental health center/clinics and DMH, to determine the size and types of programs each hospital needs to provide for adolescents within each hospital service area.

(6) By July 1, 1978, the adolescent program of each center/clinic will be mutually agreed upon between that center/clinic and DMH.

(7) By July 1, 1978, DMH will have worked jointly with other appropriate state agencies and organizations to attempt to develop a common classification system for problems and behaviors of

troubled adolescents, as well as a system to classify all facilities (public and private) which provide 24-hour care for such adolescents in the state.

(8) By October 1, 1978, each mental health center/clinic shall have written agreements with local school administrative units as to the provision of mental health services to mentally and physically handicapped adolescents, in compliance with PL 94-142 (Education of the Handicapped Act).

(9) By July 1, 1979, each adolescent program shall have been evaluated during the annual site visit, according to the Standards/Rules and Regulations for Mental Health Centers and Clinics, and the goals and objectives set forth by each center/clinic.

(10) By July 1, 1979, DMH shall have worked jointly with other appropriate state agencies and organizations toward the development of standards for mental health services in all 24-hour programs for adolescents not currently under the jurisdiction of the Department of Institutions or their parents.

(11) By July 1, 1979, each catchment area mental health center/clinic will provide mental health services to adolescents requiring partial and 24-hour care, whether or not the facilities therefor are operated by the mental health center/clinic or another agency or organization. Where such facilities are operated by another agency or organization, there must be a written agreement as to how the center/clinic shall provide mental health services to the facility.

c. Elderly:

(1) By October 1, 1977, each catchment area center/clinic will have developed an affiliation agreement with the Area Agency on Aging.

(2) By October 1, 1977, each center/clinic will submit a plan to DMH for services to the elderly, which must be approved by DMH in accordance with the annual contract.

(3) By July 1, 1978, those catchment areas with the highest Chicano elderly population (Northwest Denver, San Luis Valley, Southeast Colorado, Spanish Peaks, Adams County, Weld and Larimer County) will have a bilingual/bicultural service delivery capability.

(4) By July 1, 1978, at least one of the six catchment area programs with the largest elderly population (Northwest Denver, Northeast

Colorado, East Central, Southeast Colorado, Midwestern Colorado and West Central) will have developed at least one independent living group home as a pilot project as a joint effort with a local Area Agency on Aging.

(5) By July 1, 1978, the Geriatric Coordinators will hold biannual meetings.

d. Alcohol and Drug Abusers:

(1) By September 1, 1977, DMH and ADAD will issue a joint policy statement which requires all agencies with which ADAD or DMH contract for services to have an affiliation agreement with their local mental health or substance abuse counterpart.

(2) By November 1, 1977, ADAD and DMH will jointly establish standards for the evaluation of the substance abuse programs at Fort Logan Mental Health Center and Colorado State Hospital.

(3) By January 1, 1978, the ADAD-DMH work group will develop a follow-up report to the Human Services Policy Council and the State Health Coordinating Council on their progress in overcoming coordinated service delivery problems.

e. Rape/Sexual Abuse Victims:

(1) By July 1, 1978, at least one clinician of each center/clinic-hospital will attend a minimum of one workshop on the techniques for treatment of rape/sexual abuse victims and their families.

(2) By July 1, 1978, each center/clinic will provide consultation and education services for rape/sexual abuse victims in coordination with other community agencies, e.g., courts, hospitals, private physicians, public health, and ministerial alliances.

(3) By July 1, 1978, each center/clinic will provide consultation and education services to rape prevention programs within the catchment area.

f. Ethnic Minorities:

(1) By August 1, 1977, the State Mental Health Advisory Council will establish a minority mental health advisory committee.

(2) By October 1, 1977, DMH will build into the site evaluation process specific criteria for assessing the adequacy of services to minority groups.

(3) By January 1, 1978, each center/clinic will be required to include training in services to minorities represented in the catchment area as part of its ongoing services.

(4) By March 1, 1978, the Minority Mental Health Advisory Committee will have made recommendations concerning mental health services for minorities for inclusion in the State Mental Health Plan.

(5) By July 1, 1978, the Minority Mental Health Advisory Committee will have met with DMH at least three times.

(6) By July 1, 1978, each center/clinic-hospital will be required to provide some evidence that its staff has the cultural sensitivity and linguistic skill to serve the Spanish-speaking population through a program that is outreach oriented.

(7) By July 1, 1978, the DMH will fund a demonstration project which will focus on the special treatment needs of ethnic minorities.

(8) By July 1, 1978, the "talent bank" of minority mental health professionals will be updated.

(9) By July 1, 1979, DMH will fund a second demonstration project which will focus on the special treatment needs of ethnic minorities.

g. Rural Residents:

(1) By September 1, 1977, a differential funding model proposal which focuses on the unique fiscal needs for delivering rural mental health services will be presented to DMH by the Rural Mental Health Ad Hoc Committee.

(2) By October 1, 1977, the Rural Mental Health Ad Hoc Committee will present a position statement to the DMH on the need for a full-time staff position to coordinate and integrate rural mental health and health care systems.

(3) By January 1, 1978, a collaborative study will be conducted and the results presented by the University of Colorado Medical Center, Psychiatry Department and DMH pertaining to the feasibility of developing educational programs in rural mental health settings.

(4) By March 1, 1978, a pilot study will have been completed and the results presented to DMH by the Rural Ad Hoc Committee on the special needs of rural mental health emergency services.

h. Economically Disadvantaged Persons:

(1) By July 1, 1978, DMH staff will have met with the State Department of Social Services and the Federal Department of Health, Education and Welfare staff at least once since July 1977 to explore means of increasing the amount of Medicaid and other social service funds, and Medicare and CHAMPUS funds available to mental health centers/clinics and hospitals.

i Women:

(1) By August 1, 1977, the DMH will form an ad hoc committee to gather information relating to the mental health service needs of women and ways of effectively meeting these needs.

(2) By April 1, 1978, this information will be disseminated to centers/clinics and hospitals.

(3) By July 1, 1978, a minimum of one staff member/center or clinic will attend a workshop focused on special needs of women.

(4) By January 1, 1979, all centers/clinics and state hospitals which do not have treatment programs appropriate to the special mental health needs of women will be required to develop and document such a program.

j. High Risk Persons:

(1) By January 1, 1978, each center/clinic will submit a plan to DMH for services to high risk clients, which must be approved by DMH in accordance with the annual contract.

(2) By July 1, 1978, each catchment area agency will have begun providing services to chronically psychiatrically disabled clients in nursing and boarding homes in its catchment area.

(3) By July 1, 1979, the mental health standards for health care facilities will be implemented on a pilot basis in three nursing homes.

(4) By July 1, 1979, all nursing homes which provide services to psychiatrically disabled persons will be in compliance with the mental health standards for health care facilities.

4. Goal #4

To increase public knowledge of mental health services and ways of preventing mental illness.

(1) By August 1, 1977, the Division of Mental Health will invite centers/clinics and hospitals to submit proposals for innovative preventive programs and evaluation of these programs. At least one proposal will be approved for funding with 314(d) funds.

(2) By September 1, 1977, the DMH will have completed an assessment of public education services currently being provided by centers/clinics, hospitals, DMH and the Mental Health Association of Colorado, and will have developed a catalog of such services and will have identified possible gaps and needs.

(3) By January 1, 1978, all centers and clinics will be required to conduct or sponsor each year at least one seminar, workshop or other public education program which focuses on the prevention of mental illness.

(4) By March 1, 1978, the DMH will develop a comprehensive plan for public education services to be provided by DMH, centers/clinics and hospitals. This plan will be coordinated with the Mental Health Association.

(5) By March 1, 1978, as part of the above plan, DMH and the Mental Health Association will begin sponsoring at least one workshop or seminar per year for centers/clinics and hospital personnel responsible for public education.

(6) By July 1, 1978, all centers/clinics and hospitals will have on file with DMH their written goals and objectives for ongoing public education services within the scope of the above plan.

5. Goal #5

> To increase consultation services to other public agencies that provide services to mentally ill persons.

(1) By January 1, 1978, all centers/clinics will be required to have periodic information sharing/mutual consultation sessions with public health nurses and other appropriate public health personnel, school district(s) staff, social services staff and staff of other appropriate human services agencies in the catchment area such as clergymen and law enforcement agencies.

(2) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with public health nurses and other appropriate public health personnel concerning areas of shared responsibility and coordination of health services.

(3) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with the regional alcohol and drug abuse coordinator.

(4) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with county social services personnel to discuss mutual concerns and ways of improving services to mutual clients.

(5) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with school district staff and district and other court personnel.

CHAPTER IV

THE STATE MENTAL HEALTH PROGRAM

IV. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

(No substantive changes have been made in this section.)

B. PREADMISSION SCREENING

1. Role of Hospitals and Centers and Clinics (supercedes the first paragraph of subsection B.1. in basic plan)

The DMH policy is that to the fullest extent possible, all persons who are believed to be in need of mental health services will be screened or evaluated by the appropriate catchment area center. In order to facilitate the operationalization of this policy, Continuity of Care Committees, which include representatives of the state hospitals and centers and clinics have been formed in each hospital service area. The Committees have developed recommended criteria for admission to inpatient care at the state hospitals, and guidelines for facilitating easy movement and continuous care for clients within the system. The Committees' recommendations have been implemented on a pilot basis. Policy statements based on the Committees' work will be prepared and issued by the DMH Central Office when the trial period has expired and the procedures have been refined. The Continuity of Care Committees are permanent bodies which have the responsibility for monitoring the system and assisting in the resolution of any problems that might arise. Fort Logan Mental Health Center has established an admissions unit which greatly facilitates the referral and continuity of care process.

The assumption by centers/clinics of primary responsibility for preadmission screening has resulted in some complaints from juvenile court judges who prefer to send an adolescent who appears to require mental health services directly to a state hospital. Conferences involving the DMH, the centers/clinics, the state hospitals, the judges and other court personnel are being held to resolve this problem.

2. Procedure for Preadmission Screening by Centers and Clinics

(No substantive changes have been made in this section.)

C. ALTERNATIVES TO HOSPITALIZATION

(No substantive changes have been made in C.1-4.)

5. (added)

During the past year, the DMH placed increased emphasis on the elimination of inappropriate hospitalization through the stepped-up preadmission screening outlined above, and expanded use of residential and other alternatives to inpatient hospitalization. A specific category of service ("other 24-hour care") has been established to capture data on persons treated in residential alternatives to inpatient care, and special funding has been requested from the state legislature to pay for such care. The admissions and services review process described in the basic plan is still operational in the two state hospitals. This mechanism is designed to ensure that persons who require inpatient care receive services which are well planned, conducted and monitored. Standards for mental health services in nursing care facilities and intermediate health care facilities have been developed (a copy of the standards is included in the appendix).

D. PUBLIC MENTAL HOSPITALS

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources
   (No substantive changes have been made in this section.)

2. Efforts to Improve Quality of Institutional Care
   e. (supercedes e. in the basic plan)
      The center has established a half-time patient representative who is available to patients for discussing their concerns about the quality of care and acts as a factor in remedying of the identified problem. The patient representative is accountable to the Community Coordinator, and ultimately to the Director.
   g. Inservice training programs are available to all staff through the Office of Nursing and Training... (rather than the Division of Hospital Standards and Inservice Training).

3. Description of Present Fort Logan Mental Health Center Population
(supercedes this subsection in the basic plan)

Fort Logan Mental Health Center is organized to provide treatment to children, adolescents, adults, geriatric patients and alcoholics who have severe functional and behavioral disorders. A mental health service has been established for deaf and hearing impaired persons. The deaf services program serves the total state, but priority is given to clients from the Denver metropolitan area.

Since its beginning in 1961, the Fort Logan Mental Health Center has had a basic commitment to short-term intensive treatment and early return of the patient to community living. This has resulted in the population receiving not only inpatient care, but graduated intensities of care in transitional living facilities on grounds and living in the community. Specialized programs provide long-term maintenance and support to many patients in community living situations who formerly would have remained in the hospital. For the first half of the current fiscal year (1976-77) the average daily attendance (ADA) of this inpatient population was:

Program Division	Requirements for Admission	Inpatient ADA
Adult Psychiatric	Severe psychiatric disability	43
Alcoholism	Severe drinking problem	15
Children/Adolescent	Severe psychiatric illness	53
Geriatric and Deaf	Severe psychiatric illness (The deaf might not be as severely psychiatrically disabled as other clients; however, this is the only psychiatric service available to many deaf persons.)	19
	TOTAL:	130

During the summer of 1976, FLMHC began a major reorganization of its treatment and support services. The reorganization was initiated specifically to reduce the cost of inpatient care. One result of the reorganization was an increase from 252 to 341 in hospital and transitional living beds. The majority of the additional beds are in the Children/Adolescent Division. This will obviously result in an increase in the inpatient ADA, which will be a critical factor in the lowering of costs. While the increase in the number of beds was a by-product of the reorganization, the beds were needed, as indicated by the present level of utilization, to help meet the special inpatient treatment needs of children and

adolescents, and to provide a lockable treatment facility for adults in the Fort Logan service area. The 75-76 session of the General Assembly mandated a study (Footnote 45 of the Appropriations [Long] Bill for the fiscal year beginning July 1, 1976) of the comparative costs and outcome of services provided by the two state hospitals and residential child care facilities (RCCFs). A report was submitted, but due to the complexity of the issue, the report did not include comparative cost data for the state hospitals and the RCCFs. The 76-77 General Assembly has again mandated a study of comparative costs and outcomes. Future state funding for FLMHC's (and CSH's) children's and adolescents' services hinges on the outcome of this study.

Fort Logan is currently serving twenty-two counties, having added the six counties of Planning Region 12 to its service area in July 1976. The major portion of the population served resides in a highly urbanized area within 20-30 miles of the hospital. The population of the FLMHC service area is 1,900,000.

Within the area served by the hospital are twelve community mental health centers and four community mental health specialty and catchment area clinics. Short-term, acute care for adults is provided in local communities whenever possible. The hospital provides acute care for adult patients from northeast Colorado, Arapahoe County and on contract with some local centers. Currently, the basic responsibility of FLMHC is specialized inpatient services to children, adolescents, adults, geriatrics, alcoholism and long-term care for the chronically ill in programs designed to avoid institutionalization.

4. Plans for Avoiding Chronicity

   (No changes have been made in this section.)

5. Plans for Providing Social and Recreational Stimulation

   (No changes have been made in this section.)

6. Evolving Role of Fort Logan Mental Health Center in the Mental Health Service Delivery System (supercedes this subsection in basic plan)

   It is planned that over the next five year period the FLMHC will evolve into the role of a primary provider of short-term inpatient care for the catchment areas in the Denver metroplex, with the centers and clinics having input into admissions and treatment policies and discharge decisions. The adult inpatient and transitional ADA is expected to increase over the

next year, then stabilize at about 90 to 95 ADA. Whether there is a further increase or decline will be determined by the availability of residential alternative facilities in the various catchment areas, and the ability of centers and clinics to treat more seriously disturbed clients in non-hospital programs. Each catchment area center in the Denver metropolitan area, except Arapahoe, has an identified inpatient service within its catchment area. However, as federal staffing grants expire, cost considerations might make it advisable to centralize inpatient services for those catchment areas close to FLMHC, at FLMHC.

FLMHC will continue to provide long-term inpatient care for all age groups, and short-term inpatient care for children, adolescents and the elderly. For the foreseeable future, the Tertiary Aid and Prevention (TAP), the Lodge, family care and supervised boarding homes programs will be continued. The hospital's vocational services program for non-DVR eligible clients will also be continued.

A decision by the legislature has, for the first time, given ADAD control over state funds for alcoholism services provided by FLMHC and Colorado State Hospital. Thus, the future of the alcoholism program at FLMHC will be determined by ADAD. In that DMH and ADAD have forged a close working relationship, DMH's participation in the decision making process around FLMHC's role in the delivery of alcoholism services is ensured.

Colorado State Hospital

1. Description of Living Conditions and Treatment Resources
   (No substantive changes have been made in this section.)

2. Efforts to Improve Quality of Institutional Care
   (No substantive changes have been made in this section.)

3. Description of Present Residential Population
   (supercedes this subsection in basic plan)

The hospital groups its residents according to their functional requirements for specialized environments and clinical or rehabilitation techniques. These groupings constitute the program divisions of the hospital organization shown below. For the first half of the current fiscal year (1976-77) the average daily attendance of this inpatient population based on daily midnight bed count was:

Program Division	Requirements for Admission	Inpatient ADA
Alcoholic Treatment Center	Severe drinking problem	49
Drug Treatment Center	Severe drug abuse	35
Children/Adolescent Treatment Center	Severe psychiatric illness through age 16	69
Geriatric Treatment Center	Severe psychiatric illness for patients over age 60	157
General Adult Psychiatric Services	Acute and severe psychiatric illness for patients age 17-64	122
Division of Forensic Psychiatry	Criminal court evaluations and criminally insane	282
General Hospital Services	Medical-surgical problems	63
	TOTAL:	777

The first five program divisions serve forty-one counties of the southern and western portions of the state, with a total population of some 800,000 persons. The Division of Forensic Psychiatry and the General Hospital Services serve all sixty-three counties of the state. The General Hospital also serves non-psychiatric residents of the other state institutions.

The 34% decrease in the ADA for the Geriatrics Division is the result of a deliberate plan by CSH to transfer from the inpatient service those geriatrics patients who are capable of functioning in a less restrictive setting. The clients are carefully prepared for relocation, and appropriate arrangements are made for follow-up care as required.

4. Efforts to Avoid Chronicity

(No substantive changes have been made in this section.)

5. Provision for Social and Recreational Stimulation

(No substantive changes have been made in this section.)

6. Evolving Role of Colorado State Hospital in the Mental Health Service Delivery System (supercedes the fifth paragraph which reads "CSH will phase down its alcohol and drug abuse treatment programs...")

The Alcohol and Drug Abuse Division (ADAD), as the state alcohol and drug abuse authority, has the responsibility for planning and administering the substance abuse programs in the state. The (1976-77) session of the legislature has, for the first time, given ADAD control of the substance abuse funds which previously were administered by the Division of Mental Health. Therefore, the future of the alcohol and drug abuse programs at

CSH will be determined by ADAD. The DMH's close working relationship with ADAD ensures that DMH will have input into the decisions concerning CSH's role in the provision of substance abuse services.

E. FOLLOW-UP CARE

1. Pre-Discharge Planning Procedure
   (No substantive changes have been made in this section.)

2. Responsible Center/Clinic in Each Catchment Area
   (No substantive changes have been made in this section.)

3. Policies for Discharge from State Hospitals
   (No substantive changes have been made in this section.)

4. Methods for Assuring Availability of Follow-Up Care
   The following paragraphs are added:

Increased attention has been focused on aftercare services during the past year. The DMH state budget request included funds for specialized services to former state hospital clients who are presently living in nursing care facilities, boarding homes and other group living facilities. The legislature responded by appropriating $720,000 for services to such clients and the reduction of admissions to the state hospitals. The Mental Health Association of Colorado and the Colorado Association of Community Mental Health Centers and Clinics were instrumental in gaining legislative approval of these funds. Increased emphasis has been placed on sheltered workshops as very effective and efficient components in the array of follow-up services.

The two hospital service area Continuity of Care Committees will assist in the monitoring of the follow-up process, and will make recommendations to DMH concerning needed revisions in the policy and procedures.

F. WORKFORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Workforce (Manpower/Womanpower)

The following is a summary of the current staff of mental health centers, clinics and state hospitals in Colorado:

- IV.8 -

Discipline	Full-Time Staff	Part-Time Staff
M.D., Psychiatrist	48	70
M.D., Physician (non-psychiatrist)	10	62
Nurse, M.S.	24	4
Nurse, B.S.	109	6
Nurse, A.A.	158	5
Nurse, Practical	23	2
Mental Health Worker, B.S.	128	8
Mental Health Worker, A.A.	178	1
Mental Health Work	93	16
Social Worker, D.S.W.	1	2
Social Worker, Masters	245	33
Social Worker, Bachelor	29	4
Psychologist, Ph.D.	130	19
Psychologist, Masters	117	13
Psychologist, Bachelor	16	1
Other Doctorate Level	12	2
Other Masters Level	103	2
Other Bachelor Level	152	6
Other A.A.	12	
Psychiatric Technician	357	
Other	1241	176
Total	3186	432

Included in the "other" category are:

Information Specialists
Librarians
Teachers
Administrative Officers
Accountants
Personnel Officers
Purchasing Agents
Clerical Entry through Secretary II
Storekeepers
Supply Officers
PBX Operators
Reproduction Equipment Operators
Physical Plant Managers
Labor & Grounds Maintenance
Carpenters
Electricians
Painters
Pipefitters
Plumbers
Plasterers
Sheet Metal Workers
General Plant Mechanics
Machinists
Automotive Servicemen & Mechanics
Welders
Refrigeration Mechanics
Stationary Firemen & Engineers
Truck Drivers
Safety Inspectors
Public Safety Guards & Officers
Food Service Workers, Cooks, Bakers and Meatcutters
Dietitians
Laundry Workers & Supervisors
Barbers
Beauticians
Custodial Workers & Supervisors

2. Projection of Personnel Needs (supercedes the last paragraph which reads: "The Division of Mental Health...")

The Division of Mental Health is engaged in a statewide effort to upgrade the skill of the staff of centers, clinics, hospitals, the DMH Central Office and other mental health caregivers, administrators and lay board members through a series of workshops, seminars and other training techniques. The DMH applied for and received a continuing education grant to train the staff of mental health centers/clinics to provide the twelve services required by agencies funded under Public Law 94-63.

3. Development and Maintenance of an Adequate Supply of Mental Health Personnel (supercedes this subsection in basic plan)

The development and maintenance of an adequate supply of mental health personnel requires the joint efforts of the colleges and universities in providing the basic professional education (preservice training) and of the service delivery system in providing postgraduate or continuing education of mental health professionals and paraprofessionals.

The goals of continuing education are both individual and organizational: to maintain and update the skills of the individual clinician and to provide a mechanism for accomplishing planned changes in service delivery. The ongoing professional development of employees is essential to retain experienced personnel and to ensure that the necessary staff skills are available to effectively implement program goals and objectives. Therefore, resources for the continuing education of mental health professionals and paraprofessionals must be built in as an integral part of the service delivery system.

The term "continuing education" is used to include all those educational activities following academic professional training, whether provided by professional societies, universities, or service agencies themselves. Continuing education is distinct from "consultation and education." Whereas continuing education is aimed at the ongoing education of mental health professionals and paraprofessionals, consultation and education is directed towards the mental health education of lay citizens or non-mental health professionals such as teachers, welfare workers, clergy or law enforcement personnel.

Within the context of the service agency, continuing education is often used synonymously with the terms "staff development" and "inservice training."

It includes a diverse range of activities such as: formally organized inservice classes, seminars or workshops; case conferences and clinical consultations which are primarily oriented towards staff training; sending staff to attend externally sponsored education offerings; and development of organizational policies, structures and resources in support of the ongoing professional development of agency personnel.

The responsibility for continuing education is shared by the Division of Mental Health, the service delivery agency, and the individual mental health professional:

> The role of the Division is carried out by the Staff Development Section and includes identifying statewide training needs and priorities, setting minimum standards for continuing education, establishing and administering enabling mechanisms, and developing resources needed to support the role of service agencies.
>
> The role of the indiviudal agency includes assessing agency training needs, and providing the continuing education (staff development) services required by their staff.
>
> The role of the individual mental health professional includes the maintenance of his/her knowledge and skills in keeping with the requirements and expectations of his/her respective profession.

The implementation of these roles is enhanced through the joint efforts of the Office of Staff Development, Division of Mental Health, and the inservice directors/coordinators of the individual service agencies who together comprise the Continuing Education Committee (CEC). The CEC serves as an advisory committee to (1) the Continuing Education Grant, "Comprehensive Services Development Project" and (2) the Division of Mental Health regarding educational and training issues.

4. Procedures for Protecting Displaced Employees Rights (add the following)

No state hospital employees have been discharged or laid-off because of DMH's efforts to eliminate inappropriate hospitalization.

5. Volunteer Services (added)

Volunteer services are an important part of the history of mental health care. Modern day volunteers provide a variety of services from transporting clients to professional clinical services. Volunteers enable agencies to provide additional services, and help keep the cost of mental health care within reasonable limits. Equally as important is the community involvement and community support which the volunteers represent. They help "spread the word" about the availability of

preventive and corrective mental health care. Their presence in mental health agencies and the linkages they facilitate between the mental health center, clinic or hospital and various community organizations help breakdown the stigma often associated with mental health. It is the policy of the Division of Mental Health that all centers, clinics and hospitals have an active volunteer program.

6. Fiscal Support of the State Mental Health Program (added)

The State of Colorado has a history of strong support of its mental health programs. This state was one of the first to pass legislation which permitted state support of community mental health centers and clinics. The two state hospitals are regarded as two of the most progressive in the country. This is attributable in a large measure to the excellent fiscal support received from the legislature, especially during the 60s and early 70s.

In recent years, primarily because of poor economic conditions, it has become increasingly difficult to obtain sufficient state funding to maintain the desired level of program growth. In respect to federally funded centers, the funding problem was aggravated by the fact that the eight year federal staffing grants began to expire about the same time the economic fortunes of the state began to decline.

Despite the problems cited above, state support of mental health services has increased each year. For example, even though the state was experiencing an economic downturn, along with the rest of the country, in 1976 state support of mental health programs increased by 7.2% from FY 75-76 to FY 76-77.

In addition to actively pursuing state support, the DMH, hospitals and community agencies are attempting to find ways to maximize income from Medicaid, Medicare, CHAMPUS and other third party sources. The DMH and the centers and clinics are, with legislative encouragement, developing an incentive system which will hopefully result in an increase in income from local governments and other non-state, non-federal sources.

One of the new objectives in the Plan is the development of an estimate of the cost of implementation of this Plan. It is acknowledged that it will be difficult to accurately "cost out" the Plan; however, the best talent available will be used to develop cost estimates.

7. Standards, Rules and Regulations (added)

The following standards, rules and regulations which apply to centers/clinics and/or hospitals, have been promulgated during fiscal year 76-77. These documents will have a profound impact on the public mental health system:

a. Standards/Rules and Regulations for Mental Health Centers and Clinics (distributed under separate cover, if not included in your copy of this document)

b. Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Pursuant to CRS 1973, 27-10-101, et seq., as amended (copy in appendix)

c. Health Care Facility Standards for Persons with Mental Health Problems (copy in appendix)

d. Joint Commission on Accreditation of Hospitals (JCAH) Standards (available from JCAH).

CHAPTER V

COORDINATION OF PLANNING

V. COORDINATION OF PLANNING

A. INTERDEPARTMENTAL COMPREHENSIVE PLANNING

1. Human Services Policy Council
   (There are no substantive changes in this section.)

2. Office of State Planning and Budgeting
   (There are no substantive changes in this section.)

3. Health Planning (supercedes this section in the basic plan)

As a result of the implementation of the National Health Planning and Resources Development Act of 1974 (PL 93-641), the Colorado Health Planning Council (previously created under the former comprehensive health planning legislation) is no longer functional and the Division of Comprehensive Health Planning of the Department of Health was phased out. The Statewide Health Coordinating Council (SHCC), which will replace the Health Planning Council, has not yet been appointed by the Governor; but indications are that it will become functional by the early summer of 1977. The Colorado Department of Health has been designated as the State Health Planning and Development Agency (SHPDA) under PL 93-641, with these functions centered in the newly created Office of Medical Care Regulation and Development.

Health planning and development at the local level is now under the aegis of the three health systems agencies (HSAs) in the state, all of which have now been designated, funded and staffed. Approximately one-half of the former areawide Health Planning Councils have formed the nuclei of subarea advisory councils, which serve as local advisory groups to their respective HSAs. A primary task with which each of the HSAs is currently involved in a coordinated way with each other, is the development of a Health Systems Plan for each area. Each of these will address specific health services, including the various mental health services, will indicate to the extent feasible "how much" of each service is needed in the area and will designate guidelines and standards for the provision of each service. The three Health Systems Plans will in turn form the basis for the State Health Plan to be developed by the SHPDA and the SHCC.

Staff of DMH, SHPDA and one of the HSAs have discussed ways in which the Health Systems Plans, the State Health Plan and the State Mental Health Plan can be coordinated. An attempt will be made to develop the plans of these agencies around the following major categories:

a. Precare: This is the level at which health promotion and protection services, including mental health consultation and education services, are provided.

b. Primary Care: This is the level at which clients generally enter the health care delivery system. Outpatient, 24-hour emergency and prescreening services are primary level mental health services.

c. Intermediate Care: This level of care is more intensive in nature, and is generally utilized less frequently that primary care. Persons treated at this level have already received primary care. Partial hospitalization (day care, evening care and night care) and inpatient care are the intermediate level services provided by mental health agencies.

d. Tertiary Care: This is the most intensive and specialized level of care, and is the one most likely to be centralized or regionalized because of cost and the utilization rate. Examples of tertiary care are highly specialized services to children and the elderly which are provided in a hospital.

The federal guidelines for health planning include the following categories which are compatible with, and can be easily integrated into the precare, primary, intermediate and tertiary care model:

a. Community health promotion and protection services
b. Prevention and detection services
c. Diagnostic and treatment services
d. Habilitation and rehabilitation services
e. Maintenance services
f. Support services
g. Health system enabling services

Since the HSA and State Health Plans have not been written, the State Mental Health Plan will follow the present format during this first update year. The 1978-79 update will involve a complete rewriting of the State Mental Health Plan. That document will mark the beginning of the shift from the present format to the taxonomy for the State Health Plan developed pursuant to PL 93-641. Since July 1, 1976, there have been quarterly meetings between DMH and SHPDA staff. A SHPDA staff member participated in the writing of this section of the Plan, and the reivew of the total Plan.

4. Health Facilities Advisory Council

(There are no substantive changes in this section.)

B. INTERDEPARTMENTAL PROGRAM PLANNING

1. Alcohol and Drug Abuse Division (supercedes this section in basic plan)

The Alcohol and Drug Abuse Division (ADAD) within the State Department of Health is, by statute, the state alcohol and drug abuse authority. ADAD is responsible for formulation of the State Alcohol and Drug Abuse (or substance abuse) Plan.

ADAD does not directly provide treatment services, but purchases services from approved agencies across the state. In fiscal year 1976-77, the state general fund appropriation to ADAD was $2,976,941.00. In addition, ADAD was allocated $3,710,984.00 in federal funds.

Mental health agencies are becoming increasingly involved in providing substance abuse services. During fiscal year 1976-77, ADAD had 29 contracts with mental health centers/clinics (including the Drug Treatment Center at Colorado State Hospital) to provide drug and alcohol services. During this same period of time, state general funds of approximately 1.35 million dollars were appropriated to the alcohol treatment programs at Colorado State Hospital (CSH) and the Fort Logan Mental Health Center (FLMHC), and CSH received an additional 0.63 million dollars for drug treatment services.

At the request of ADAD and DMH, the state legislature (76-77 session) gave ADAD direct control of the two state hospitals' alcoholism services funds. This will enable ADAD to develop a truly comprehensive statewide substance abuse plan and program. It is expected that DMH will have input into the decision concerning the role of the two state hospitals in the substance abuse program.

The close working relationship between ADAD and DMH has resulted in a number of solid achievements during fiscal year 1976-77. These include:

a. Representatives from DMH and ADAD have met monthly since September 1976 to discuss ways of resolving the service delivery issues raised in the State Plan.

b. A letter of agreement has been signed by the two Division Directors which supports joint annual evaluations of the substance abuse programs in the two state hospitals and the community mental health centers/clinics.

c. DMH and ADAD have coordinated procedures for the use of compatible data forms.

d. Each division has taken steps to facilitate increased input into its State Plan by the other division.

e. DMH and ADAD have jointly conducted continuing education efforts related to substance abuse issues for mental health agency staff.

During the coming year, close interdepartmental planning and coordination will continue with an emphasis on the objectives listed in Chapter III. This will ensure the establishment of specific standards, which will be used for the evaluation of the substance abuse programs at CSH and FLMHC by DMH and ADAD staff.

2. Department of Social Services (supercedes this subsection in basic plan)

The Department of Social Services (DSS) is responsible for the provision and/or fiscal administration of a host of social and medical assistance programs. DMH and DSS have many common interests and concerns, including mutual responsibilities for clients receiving services from both agencies. Through DSS, social services and financial assistance are provided to many clients of the mental health agencies. Additionally, DSS programs make possible reimbursement for mental health and rehabilitation services to emotionally disabled children, adolescents, adults and aged persons.

Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) receive Title XIX (Medicaid) and vocational rehabilitation funds from DSS. Mental health centers and clinics are recipients of Medicaid funds for services to eligible clients. Unpredictable and severe reductions in vocational rehabilitation funding have resulted in major changes and periods of uncertainty in the vocational rehabilitation programs in the hospitals and several centers. Differing interpretations as to which services of centers and clinics are eligible for Medicaid reimbursement, and restrictive Medicaid requirements (such as the physician on the premises requirement) which are difficult and fiscally impractical at least in some non-urban areas, severely limit the income to centers and clinics. Also, in contrast to the practice in many other states, the Title XX funds are virtually unavailable for the purchase of mental health services because of the prior commitment of these funds for child care and other services provided by agencies other than mental health centers and clinics. Continuing efforts are being made to include mental health services in the Title XX plan at a more viable level.

Increased coordination in planning will be developed between DSS and DMH, as well as between the centers/clinics and county social service departments. Outcomes to be expected include: improved coordination and facilitation of referrals for services; expanded vocational rehabilitation services for mental health clients; additional funds, available with a minimum of obstacles, for mental health services to persons eligible for medical assistance under Medicaid; and coordinated provision of services for the elderly.

3. Department of Education (supercedes this section in the basic plan)

Coordination of planning between the Department of Education and mental health services of the Department of Institutions is included in the policy development activities of the Human Services Policy Council. Additionally, a representative of the Division of Mental Health has provided input to plans of the Division of Special Education of the Department of Education.

At present there are some areas of program coordination between mental health agencies and the Department of Education. Under provisions of the state Handicapped Children's Educational Act, school districts and boards of cooperative services may contract with mental health centers or clinics to purchase diagnostic evaluation services for handicapped children, teacher and parent counseling or consultation, and inservice education for school staff and volunteers. Therapy services for children are not eligible for reimbursement to mental health agencies.

Limited amounts of funds from the Elementary and Secondary Education Act (federal), administered through the Department of Education, have been available to supplement the school programs at the two state hospitals. A General Accounting Office audit team recently visited the CSH ESEA program and expressed concern that the ESEA funds appear to be the primary funding for the program rather than supplemental funds, as they were intended to be.

An area of planning being addressed by the Human Services Policy Council is services for the handicapped. Certainly education of the emotionally handicapped will be included in the development of policies and program goals. In addition, specific program coordination mechanisms should be developed:

a. a representative of the mental health system should be included in the membership of the State Special Education Advisory Committee;

b. a coordinating group, representing the Divisions of Mental Health, Developmental Disabilities, Youth Services, the Department of Social Services and Division of Special Education should be created to plan and implement programs which will provide educational services to children excluded from public schools because of emotional handicaps and/or residing in residential treatment facilities and have emotional handicaps;

c. changes in legislation should be sought to provide that local, state and federal funds for education of the handicapped will be available at an adequate level to community or residential agencies which include educational services in treatment programs for the emotionally handicapped;

d. the child with multiple handicaps (such as mental retardation and mental illness) must receive services for each handicap by the agency with the primary responsibility to deliver that service. This will require joint treatment planning and joint service provision. No child should be denied the appropriate treatment for a "secondary diagnosis."

4. Department of Corrections (added)

The 1976-77 session of the Colorado General Assembly has enacted legislation which elevates Correctional Services from divisional to departmental status. Thus, Correctional Services, which was a sister division to DMH, becomes a peer of the Department of Institutions. It is generally acknowledged that mental health services for persons in the correctional system are inadequate. The role of DMH (particularly Colorado State Hospital, which has provided a variety of services to the Penitentiary and Reformatory) will be discussed with Corrections officials when the restructuring of the new department has been completed.

C. INTERDIVISIONAL PLANNING - DEPARTMENT OF INSTITUTIONS (supercedes this section in the basic plan)

During the past year, legislative action has resulted in the shift of the Division for the Deaf and Blind from the Department of Institutions to the Department of Education, and the elevation of the Division of Correctional Services to departmental status. Thus, the Department of Institutions is now comprised of three divisions: Developmental Disabilities, Youth Services and Mental Health. All three of the divisions have "institutional" residential facilities, and all utilize community based facilities which they operate directly or through contractual arrangements with other agencies. Each of the three divisions has a strong commitment to the provision of services in the least restrictive setting, and the prevention of inappropriate institutionalization.

The Divisions of Mental Health and Developmental Disabilities plan to engage in a variety of joint activities to increase and improve the quality of mental health services to the developmentally disabled including:

1. Facilitating a face to face meeting between individual community mental health centers/clinics and community center board directors and DD program directors.
2. Assessing service needs in terms of types of client problems and and types of services needed to address the problems.
3. Assessing the amount of services needed in terms of the numbers of clients needing specific types of service.
4. Defining and planning inservice training programs which mental health centers/clinics can provide to community centered boards.
5. Defining and planning inservice training which community centered boards can make available to mental health centers/clinics.
6. Defining and planning inservice training either or both types of agencies may seek from an outside training or consultation resource.

The Divisions will be supported in this effort by the Developmental Disabilities Council, the Colorado Association for Retarded Citizens and the Mental Health Association of Colorado.

The Interdivisional Placement Team, with a representative from each division, reviews information about hard-to-place clients, designs a

plan for treatment which may involve services to be provided by two or more divisions, monitors the progress of treatment, and makes recommendations to the Executive Director about the need for new programs or revised structure of services to meet client needs.

The interface between the DMH and the Division of Youth Services has been carried on primarily through the Interdivisional Placement Team. Problems between the two divisions have primarily revolved around which division should have the primary responsibility for the treatment of especially difficult clients. The problems have been exacerbated by judicial actions which sometimes result in inappropriate placement in a youth service or mental health facility. The problems are further compounded by the lack of definitive criteria for determining the most appropriate placement for pre-delinquent and delinquent youth, some overlap between the treatment functions of mental health and youth services facilities, and differences in treatment philosophies, approaches and expectations. The DMH recently took steps to initiate a dialogue between the Division of Youth Services and Fort Logan Mental Health Center with a view toward facilitating collaborative action on the problem areas. The Division has also initiated a series of conferences involving the juvenile judges and representatives of the centers/clinics, the Judicial Department, Social Services, as well as FLMHC and the Division of Youth Services. The purposes of the conferences include finding ways to reduce the time required to respond to the courts' requests for diagnostic assessments, to gain a clear understanding of the various statutes involved, and to attempt to remove - or reduce - the barriers to humane, efficient and effective services for delinquent and pre-delinquent youth.

The Interdivisional Medical Services Committee, which has representatives from all three divisions, surveys the adequacy of medical and related services in agencies of the Department of Institutions, including laboratory facilities and pharmacy services. Recommendations are presented to the Executive Director to improve the quality and efficiency of these programs.

D. LOCAL GOVERNMENTAL PLANNING AND REGIONAL PLANNING

(No substantive changes have been made in this section.)

E. PUBLIC, VOLUNTARY, AND PRIVATE MENTAL HEALTH SERVICES

(No substantive changes have been made in this section.)

CHAPTER VI

CATCHMENT AREA MENTAL HEALTH PROGRAM

VI. CATCHMENT AREA MENTAL HEALTH PROGRAM

A. DESCRIPTION OF CATCHMENT AREAS

(No substantive changes in pages 1-4.)

On page 5, add the following after the paragraph which reads "Following is a brief description of each region, the services provided by the centers/clinics serving the region and program needs." (See Appendix IV for a chart showing the availability of the twelve PL 94-63 services in the 21 catchment areas.)

The population data are based on projections by the State Division of Planning, Department of Local Affairs. The data do not include military personnel and their dependents. Excluded military personnel and dependents are as follows: Adams - 5,287; Arapahoe - 10,460; Denver - 14,253; El Paso 80,000. All data are as of January 1, 1978.

REGION I

(supercedes the description in the basic plan)

Area: 9,228 square miles

Population: 67,155

Composition of Population:		
	Anglo	93%
	Asian	-0-
	Black	-0-
	Chicano	7%
	Native American	-0-
	Other	-0-

1. Existing Services

The region is served by the Northeast Colorado Mental Health Clinic with headquarters in Sterling and branch offices in Fort Morgan, Yuma and Holyoke. Outreach services are provided to other communities in the region. County fiscal support of the clinic has been impressive; over the past several years, county funds have accounted for approximately one-third of the total budget of the clinic. The major service modalities of the clinic are outpatient evaluation and treatment services; juvenile diagnostic crisis shelter, counseling services, and residential treatment programs; and consultation and education services to other community agencies. A grant is being submitted for a multi-agency diversion project

for pre- and post-adjudicated adolescents. Emergency services are available 24 hours a day. A contract with the Alcohol and Drug Abuse Division (Department of Health) supports client counseling, public education, community organization efforts and training programs in alcoholism in the region. A partial care program has been initiated in one local nursing home, while ten 24-hour alternative beds have been established in a second one.

2. Program Needs

With the above-average community support generated by the Northeast Clinic, the establishment of a wide range of mental health services will be possible within the next few years.

There are no hospitals within the catchment area providing separate units, beds or professional staff to treat serious emotionally or socially disturbed persons. The nine general hospitals will admit patients with a psychotic disorder or diagnosis, but they are not staffed for treating such disturbances other than on a limited emergency basis. There is a need for specialized inpatient services and additional alternative treatment facilities in the catchment area.

A planning grant application was submitted and approved by the Department of Health, Education and Welfare to facilitate the establishment of comprehensive services to this catchment area and to the Region 5 catchment area. No monies were available and the grant has been resubmitted. Under this proposal, Regions 1 and 5 would be combined into a single catchment area so that comprehensive services would be made available to both areas.

The ADAMHA Regional Office has approved the merger of the two regions; however, that office is aware of the careful planning that must take place to accomplish a merger of two established agencies. As previously indicated, the planning grant has not been funded; therefore, action on the merger has been delayed. The two agencies and the two catchment areas are maintaining their separate identities until the planning process has been properly completed.

While the area of combined Regions 1 and 5 is very large, the population of these contiguous areas is quite sparse. Resources are scarce in both regions. The regions share many geographic, economic, political and social factors which increase the feasibility of amalgamation for the purposes of provision of comprehensive mental health services. Many

of the Northeast Colorado Mental Health Clinic staff provide services on a part-time basis to Region 5.

Thus far, there is joint utilization by the two clinics of a child/adolescent crisis center and of a juvenile residential treatment program. They have also jointly hired an accountant.

REGION 2a

(supercedes the description in the basic plan)

Area: 4,004 square miles

Population: 123,412

Composition of Population:		
	Anglo	82.1%
	Asian	.8%
	Black	.3%
	Chicano	16.0%
	Native American	.2%
	Other	.6%

1. Existing Services

The county is served by the Weld Mental Health Center. The center received a federal staffing grant in November 1967, and the grant terminated in October 1975. Based upon the 1960 census data, the county was designated as a poverty area, and the center became eligible for poverty funding status. However, 1970 census data did not support continued poverty area designation of Weld County. No fiscal support of the program is received from the county; funding comes entirely from federal and state sources, fees, donations, and modest school contract funds and some support from the City of Greeley. The main service center and administrative offices recently moved into a new, well designed facility in Greeley.

There is a branch office in Fort Lupton, a community south of Greeley wherein a large proportion of the county's Chicano population resides. The center is attempting to increase its outreach efforts to Chicanos in the county and has made major strides, although additional resources need to be channeled into this effort.

Inpatient services are provided in the county hospital in Greeley, and the inpatient program is often filled to capacity. Adult day care services are provided through a separately organized facility called "Stepping Stone," which provides services for both chronic, longer term clients and clients in the inpatient unit. Emergency services are provided throughout the county. Fort Logan Mental Health Center is the state hospital serving this region.

A full range of services is available for the alcoholic and his family through the various center services and a specialized alcoholism outreach team. A halfway house provides an alternative living program for the alcoholic.

A specialized program for children and families provides emergency care, long-term therapy, evaluation services, and a child partial care treatment program, as of 3-1-77. A drug treatment/drug preventative program, "Horizons," for teenagers and young adults is well utilized as a drop-in center in the community. A conversion grant, beginning 7-1-76, has supported the development of transitional care and peer counseling (home visits, etc.) for the elderly.

2. Program Needs

The Weld Center provides basic services for all categories of clients with the exception of forensic services and specialized inpatient services for children and adolescents. The possibility of some sharing of facilities and services by Weld and Larimer Counties will be explored.

Perhaps the highest priority for this region is the development of other 24-hour care services, such as a halfway house, to relieve the growing pressure on the center's inpatient program.

There are no transitional care beds currently available for children or adolescents with chronic psychiatric problems and behavioral problems requiring intensive mental health treatment. The center proposes a 12 bed facility which would offer intensive treatment and educational-oriented programs in conjunction with the local department of social services, the local school district and the local center for the developmentally disabled. This facility would make possible a reduction in the number of children being inappropriately institutionalized in both psychiatric hospitals and juvenile detention facilities.

REGION 2b

Area: 2,614 square miles

Population: 132,806 (supercedes figure in basic plan)

Composition of Population:		
	Anglo	91.9%
	Asian	-0-
	Black	.3%
	Chicano	6.7%
	Native American	.1%
	Other	1.0%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (supercedes description in basic plan)

Program needs include alternative treatment facilities for the high-risk/high resource users for all ages, increased services to outlying areas, and increased outreach to the elderly, to the Chicano population and services in relation to crime and law enforcement. The federal grant and the additional state and local funding available will help meet some of these needs.

The disasterous flood referred to above created many additional demands for services beyond the capacity of the agency to meet with existing resources. The center has received a contract for counseling services to surviving disaster victims and the families of those who did not survive.

REGION 3

Area: 5,045 square miles
Population: 1,422,393 (supercedes figure in the basic plan)

Add the following paragraph on page 14 before the paragraph which reads: "A brief description of the centers and clinics in Region 3 follows."

In 1974, the state legislature mandated the development of a plan for coordinating mental health services in the City and County of Denver. The agencies concerned, with considerable input and assistance from the Mental Health Association, the Region VIII ADAMHA Office, the Denver Department of Health and Hospitals and the Division of Mental Health, developed a plan which was accepted by the legislature. The Denver Mental Health Plan provided for the formation of a citizens' advisory group, to be known as the Denver Mental Health Advisory Board, to oversee the implementation of the Plan.

The primary thrust of the Plan is the provision of coordinated comprehensive mental health services in Denver. The Plan provided for a number of changes including the centralization of some services to eliminate unnecessary duplication, and the funnelling of state and federal funds for all Denver mental health agencies through a central fiscal agent.

The Denver Mental Health Advisory Board, the Department of Health and Hospitals, and the centers and clinics have made some progress towards the achievement of the goals. Many legal and other problems have been encountered, but all parties have invested a considerable amount of time and effort into the project and are determined to implement the Plan in the best possible way.

Adams County Mental Health Center, Inc.

Population: 190,630 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	77.7%
	Asian	-0-
	Black	2.0%
	Chicano	18.0%
	Native American	.9%
	Other(includes Asian)	1.4%

(No substantive changes have been made in the description.)

Arapahoe Mental Health Center, Inc.

Population: 141,968 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	92.64%
	Asian	.32%
	Black	.96%
	Chicano	4.48%
	Native American	1.12%
	Other	.48%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (supercedes the description in the basic plan)

This center is placing major emphasis on further refinement of its alternatives to inpatient care program, and on increasing services to children and adolescents, the elderly and the Chicano residents of its catchment area.

Aurora Mental Health Center, Inc.

Population: 105,733 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	94.5%
	Asian	.6%
	Black	1.9%
	Chicano	1.6%
	Native American	.5%
	Other	.9%

1. Existing Services

This center is the most recently developed catchment area program in the state mental health system. The new operations grant has allowed for the development of comprehensive services in inpatient, outpatient, consultation and education, other 24-hour care, partial care and pre-hospital screening. Services which are in the process of being activated include: children/adolescents, elderly, hospital follow-up and substance abuse.

2. Program Needs

Emphasis will be placed on crisis intervention and alternatives to hospitalization. Also, increased attention will be given to services to the more rural eastern end of the catchment area.

Bethesda Community Mental Health Center

Population: 126,683 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	94.3%
	Asian	-0-
	Black	.4%
	Chicano	4.5%
	Native American	.2%
	Other	.6%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (the following supercedes paragraph 2)

The center recognizes the need for increased services to members of ethnic minorities in its catchment area and is taking steps to meet this need. Efforts are also underway to increase services to the elderly and substance abusers.

Mental Health Center of Boulder County, Inc.

Population: 168,923 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	91.0%
	Asian	>1%
	Black	>1%
	Chicano	6.2%
	Native American	>1%
	Other	>1%

1. Existing Services

This is a comprehensive center which serves a diverse catchment area including both urban and rural areas. Programs are therefore geared to these specific populations (e.g., many bilingual therapists are on the center's staff). Services in all parts of the catchment area emphasize services to young adults (including a large drug-abusing population) and to families. Services in rural areas are highly accessible with good utilization by all demographic subgroups, especially the poor and minorities.

2. Program Needs

This center has a great need to provide more services for children and the elderly. Boulder is a county with a highly transient population. This rapid growth and transience creates needs for mental health services that are not fully indicated by the usual socio-demographic indicators. A transitional care facility for reducing hospital admissions is also a priority need in the county. Additional services are also needed in rural areas of the county.

Children's and Adolescents' Mental Health Services (supercedes the description in the basic plan)

(This is a non-catchmented, specialty program.)

1. Existing Services

This program provides mental health services in a medical facility which specializes in providing comprehensive physical and mental health services to children and adolescents. The mental health services are provided by professionals with specialized training in the evaluation, care and treatment of children, adolescents and their parents. The services are inpatient, outpatient and consultation and education. A unique service is the specialized outpatient services which are provided children while in the hospital for serious diseases with secondary emotional problems.

2. Program Needs

This agency will continue to play an important role in the mental health system because of its specialized services and its professional quality of care. The outpatient services were expanded in FY 76-77 and an inpatient psychiatric unit was opened in early 1977. Continued funding

and support will be required to maintain this service which will continue to expand and grow with the statewide demand for service.

Denver Mental Health Center, Inc. (supercedes the description in the basic plan)

(This is a non-catchmented, specialty program)

1. Existing Services

The clinic complements other mental health services in the Denver metropolitan area by providing longer term therapy for people of middle and lower incomes.

2. Program Needs

The clinic plans to continue expanding its outpatient services to the elderly, high-risk, and lower income populations of the Denver metropolitan area. The clinic also recognizes its need to continue expanding its availability of specialized services and collaboration with other centers.

Northwest Denver Mental Health Center

Population: 168,861 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	58.7%
	Asian	.7%
	Black	10.1%
	Chicano	29.5%
	Native American	1.0%
	Other	-0-

(No substantive changes have been made in the description.)

Jefferson County Mental Health Center, Inc. (supercedes description in basic plan)

Population: 316,028

Composition of Population:		
	Anglo	91%
	Asian	1%
	Black	.6%
	Chicano	7%
	Native American	.4%
	Other	

1. Existing Services

This comprehensive community mental health center offers comprehensive services to Jefferson, Clear Creek and Gilpin Counties which have a total population of well over 300,000 residents, making it one of the largest

in the United States. The main administrative offices are located in Lakewood with branch offices in Arvada, Evergreen, Wheat Ridge/Golden, South Jefferson and Lakewood. Part-time offices serve Idaho Springs and Georgetown in Clear Creek County.

2. Program Needs

The rapidly expanding population of these suburban and mountain counties has placed growing stress on the center to meet basic service demands. Since staffing patterns have remained more or less constant the past two years, careful utilization of staff time has been required to maximize efficiency. Services to Clear Creek County have been expanded, and efforts are underway to provide increased services to Gilpin County. The development of alternative residential facilities is being pushed, and increased services to the residents of nursing homes is another primary need in this catchment area. Expansion of the partial care program is presently underway.

This catchment area is well beyond the federal guideline for maximum population of a catchment area. The board and staff have been actively developing, in collaboration with ADAMHA staff, a plan for the resolution of this problem. The plan, as tentatively approved by ADAMHA provides for the formation of three semi-autonomous subcatchment areas. Each subcatchment area will have an Area Governing Board, however, governance of the total center will continue to be vested in a central governing board. The Area Boards will be composed of representatives of the Center Board who live in the various subcatchment areas.

The Area Boards will have the authority to hire and fire the Area Coordinator, with the concurrence of the Executive Director. The Area Boards will also carry out need assessment, will develop their own budget requests, and will be able to develop their own method of raising funds. This authority, and the other powers delegated to the Area Boards appear to provide the local community input and control essential to the community mental health concept.

The integration and cohesiveness of the total program will be assured by a strong internal communications system and ongoing centralized evaluation and monitoring of the center as a whole. A sixteen step implementation timetable has been developed to facilitate orderly movement to the new structure.

Servicios de La Raza (supercedes the description in the basic plan)
(This is a non-catchmented, specialty program.)

1. Existing Services

This program provides outpatient and emergency as well as consultation and education services of a specialized nature to the Spanish-speaking community of Denver. The program is entering its third year and is currently enjoying increasing utilization by the target group it is programmed to serve. Since it is a non-catchmented program, it is important for this staff to carefully coordinate its activities with the nearby catchment area programs as well as other community agencies.

2. Program Needs

This program needs to expand its services to elderly and children whose primary language is Spanish. In addition, the provision of consultation and education to other agencies concerning the special cultural factors involved in working with Chicano clients continues to be an area of need.

Southwest Denver Community Mental Health Services, Inc.

Population: 90,461 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	75.3%
	Asian	-0-
	Black	.2%
	Chicano	24.5%
	Native American	-0-
	Other	-0-

(No substantive changes have been made in the description.)

Park East Comprehensive Community Mental Health Center (supercedes description in basic plan)

Population: 113,106

Composition of Population:		
	Anglo	65.4%
	Asian	-0-
	Black	24.4%
	Chicano	8.5%
	Native American	-0-
	Other*	1.7%

*Native American and Asian American included in Other.

1. Existing Services

The center provides a wide range of programs which continue to be developed in the areas of children, adolescents, families, elderly and

other groups. These programs reflect the conscious effort to recognize the importance of specific life, cultural and ethnic backgrounds. The multi-lingual staff can provide services to clients who speak the following languages: Spanish, English, Japanese, German, Vietnamese, Dutch, Indonesian.

2. Program Needs

The center recognizes the need for increased services to families, children, adolescents and elderly. Alternatives to 24-hour inpatient care is a high priority, as is the establishment of an outpost in Montbello.

REGION 4

(supercedes the description in the basic plan)

Area: 4,878 square miles

Population: 248,128

Composition of Population:		
	Anglo	82.4%
	Asian	-0-
	Black	5.6%
	Chicano	10.5%
	Native American	-0-
	Other*	1.5%

*Native American and Asian included in Other.

1. Existing Services

This area is served by the Pikes Peak Family Counseling and Mental Health Center, which was formed in 1970 through a merger of Pikes Peak Mental Health Clinic and Family Counseling Service of Colorado Springs. The center's request for a federal staffing grant was approved, but because of presidential impoundment, was never funded. In July 1973, the State of Colorado funded a modified version of this staffing proposal.

The Geographic Outpatient Services consist of four major team offices with several satellite offices. Team 1 is the "core city" office and has a staff which reflects the ethnic diversity of its area. Team 2, the Fountain Valley Office, is located in Widefield, southeast of Colorado Springs. Team 3, the Northeast Office, serves the fastest growing section of the three county area. Finally, Team 4 is located in Manitou Springs and serves all of western and northern El Paso County, as well as Park and Teller Counties. Satellite offices are located in Bailey, Fairplay, Cripple Creek and Woodland Park.

The Hospital Services Unit maintains an 11 bed psychiatric unit at Penrose Hospital. The Adult Day Treatment Unit provides a high intensity outpatient program which allows clients to remain at home and maintain their work, family and social roles. The After-Hours Emergency Services have been incorporated into an emergency services unit, providing 365 day, year-round emergency services.

The special services are comprised of various programs geared to the specialized needs of individuals in the catchment area. Adult Forensic Services is a community-based mental health program for offenders and their families. The program's services include alternative sentencing evaluations for the courts, outpatient group therapy and residential treatment for adult offenders. The Youth Treatment Center offers residential, outpatient and day treatment services to the youth in the community. Consumer Credit Counseling provides counseling to families and individuals with financial problems, as well as an extensive education program to prevent such problems.

The alcohol services offer a variety of programs and treatment intensities specially designed for people with alcohol related problems.

2. Program Needs

A substantial increase in other 24-hour care beds is needed. Such beds are essential if the center is to attain its objectives related to reducing the rate of inpatient hospitalization and treating clients in the least restrictive setting.

Despite the center's Youth Treatment Center (YTC), the community as a whole has a serious gap in mental health diagnostic and treatment services for children and youth. In addition, the problem of child abuse in this area continues to be acute, and there is an obvious need for both treatment and prevention programs focused on this problem. Additional funding is also needed for improvements in YTC to ensure continued accreditation.

The center is currently underserving the elderly people in its catchment area. Although services to elderly have recently improved, additional resources and efforts are needed to provide outpatient and day care programs to maintain the elderly person at an acceptable level of self-sufficiency.

The mental health center is also under pressure to increase outpatient and consultation and education services to the continually expanding population in the catchment area. In addition, the center hopes to

expand its emergency services to include a crisis and screening residential center as resources become available.

The center is encountering some funding problems in its Alcoholism and Adult Forensic Services Programs. Despite a considerable financial outlay for improvement in the Youth Treatment Center (YTC), there is some uncertainty as to how long the YTC facility will meet minimum standards for accreditation by the Joint Commission on Accreditation of Psychiatric Facilities. Every effort is being made to maintain the above much needed services, but the center might have to consider dramatically reducing or terminating these activities if sufficient funding is not available to adequately maintain them.

The population of this catchment area (including military personnel and dependents) exceeds the allowable federal maximum of 250,000. During the past year, the center has engaged in a careful study of a variety of alternatives for the resolution of this problem. Conferences have been held with the several subcatchment area advisory boards, an out-of-state consultant was engaged to analyze the make-up of the community and to make recommendations for consideration by the board. Consultative input has also been sought from a number of other sources including Mr. Dan Townsend of the National Institute of Mental Health, the Georgia Consortia for Mental Health Services, Jefferson County and Colorado West Mental Health Centers in Colorado, and the ADAMHA Regional Office. After carefully considering the information and advice from the many sources and resources, the center has decided to request a waiver of the 250,000 maximum population requirement.

The waiver request will be accompanied by a plan for the delegation of increased authority to Area Boards. The central governing board will maintain overall responsibility for governance. However, the various subcatchment areas will be represented on the central governing board. The Area Boards' authority will embrace:

a. assessment of local needs;
b. budget planning for the local unit;
c. evaluation of the local program;
d. evaluation of the operational effectiveness of the local unit;
e. evaluation of the impact of services on need; and
f. participation in the selection of unit directors.

The responsibility for the development of the plan and a timetable for implementation has been assigned to a very capable board member. Board action on the proposal is expected within the next several weeks.

REGION 5

(supercedes the description in the basic plan)

Area: 8,401 square miles

Population: 21,173

Composition of Population:		
	Anglo	96%
	Asian	-0-
	Black	-0-
	Chicano	4%
	Native American	-0-
	Other	-0-

1. Existing Services

At present, the region is served by a part-time clinic headquartered in Flagler. This clinic was the last to develop in the state in a previously unserved catchment area. The clinic is headed by a part-time director who maintains a private psychiatric practice in Denver, but travels to the catchment area at regular intervals. Presently, outpatient evaluation and treatment programs, alcohol and drug abuse counseling, psychological testing and evaluations, and consultation and education services are offered on a limited basis. Although the area has limited mental health facilities, arrangements have been developed for utilization of a child/adolescent crisis center and of a juvenile residential treatment program in Region 1 and of a sheltered workshop primarily for the developmentally disabled in Burlington. Clients are now screened and transported to Colorado State Hospital with follow-up care provided by the clinic.

2. Program Needs

The mental health needs of the region are quite basic. Foremost is, perhaps, the establishment of a full-time outpatient clinic to serve the area. The 3.5 clinical full-time positions are primarily filled by several part-time clinicians from Region 1. A planning grant was submitted and approved by the Department of Health, Education and Welfare to facilitate the development of comprehensive services for this region. No monies were available and the grant has been resubmitted. Under this grant concept, Region 1 and Region 5 could be combined so that comprehensive

services to this large, isolated area would become feasible. The two clinics have, thus far, jointly hired an accountant.

The area needs emergency services for the citizens of this region. Local facilities for short-term care and alternative residential facilities would avoid extended absence at Colorado State Hospital from the community.

There is considerable need for mental health care of chronic, predominately aged clients. The available nursing homes are not adequately staffed to furnish quality psychiatric care. However, beds could be effectively used in existing nursing homes by upgrading their staffing patterns.

The region lacks day care facilities for disturbed youth as well as adults.

REGION 6

Area: 9,526 square miles

Population: 59,417 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	80.97%
	Asian	-0-
	Black	.35%
	Chicano	17.81%
	Native American	.15%
	Other	.72%

(No substantive changes have been made in the description.)

REGION 7

Area: 8,773 square miles

Population: 151,785 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	57.5%
	Asian	.4%
	Black	.8%
	Chicano	39.1%
	Native American	.1%
	Other	2.1%

(No substantive changes have been made in the description.)

REGION 8

Area: 8,180 square miles

Population: 43,490 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	51.6%
	Asian	.4%
	Black	.15%
	Chicano	47.0%
	Native American	.15%
	Other	.7%

(No substantive changes have been made in the description.)

REGION 9

(supercedes description in the basic plan)

Area: 6,563 square miles

Population: 46,126

Composition of Population:		
	Anglo	76.2%
	Asian	-0-
	Black	.1%
	Chicano	18.2%
	Native American	5.5%
	Other	-0-

Region 9 lies in the southwest corner of Colorado and forms part of the Four Corners area. Archuleta, Dolores, La Plata, Montezuma and San Juan are the district's constituent counties. The San Miguel drainage basin bounds the area to the north, the official dividing line being the borders of San Miguel, Ouray, Hinsdale and Mineral Counties. Conejos County limits the area's eastern extent and New Mexico and Utah border the region to the south and west respectively. The Ute Mountain Indian Reservation along with the Southern Ute Indian Reservation form the southern boundary of the region.

Mineral extraction is a primary economic activity in Region 9. Mining products include pyrite, lead, zinc, silver, copper, gold, coal, uranium, sand and gravel. The mining of coal is developing into a major industry with a rapid growth anticipated. Tourism and lumbering also contribute to the economy of the region with the tourist industry becoming increasingly significant. As the names of the counties suggest, the region has many Chicano and Indian residents. This region has the highest

unemployment rate of any region in the state. It is relatively isolated by mountains and distance from the major Colorado cities. Denver is 332 miles away and Colorado State Hospital, which serves this region, is 271 miles away.

1. Existing Services

Southwest Colorado Mental Health Center, the only public mental health agency in the area, is an outpatient clinic providing outpatient care, consultation and education and aftercare treatment to patients of all age groups. A special outpatient drug abuse program was also funded five years ago. The staff consists of 12 full-time equivalent positions, and provides services at full-time offices in Durango and Cortez. Satellite offices are located at Pagosa Springs, Dolores and Dove Creek, which are staffed on a part-time basis. Local hospitals in Durango are utilized for inpatient care for some clients who are eligible for Medicare and Medicaid and other third party reimbursements.

2. Program Needs

Southwest Colorado's greatest need is for additional staff to reach out to currently unserved or underserved populations. This catchment area has a high concentration of Native Americans and Chicanos for whom services are only minimally available. A pilot project has resulted in the development of a halfway house, adult psychiatric clients and other adult clients who require a 24-hour residential care facility, and a partial care (day care) program in collaboration with the Four Corners Sheltered Workshop at the workshop's facilities in Durango, Cortez and Pagosa Springs. The need for bilingual staff has been seen as a need to serve this multi-cultured catchment area, so staff fluent in Spanish have been hired.

The center continues to pursue a planning grant application under PL 94-63, the objective being to plan for the provision of comprehensive mental health services for the region.

Some additional specific program needs are: (a) more local inpatient psychiatric beds; (b) expansion of the center's adult, adolescent and children's outpatient services; (c) a treatment program to meet the needs of elderly people; and (d) expanded consultation and education services.

REGION 10

(supercedes description in the basic plan)

Area: 9,369 square miles

Population: 48,691

Composition of Population:		
	Anglo	89 %
	Asian	.5%
	Black	.1%
	Chicano	9.2%
	Native American	.9%
	Other	.3%

Planning Region 10 consists of Delta, Gunnison, Hinsdale, Montrose, Ouray and San Miguel Counties. This area roughly corresponds to the drainage basins of the Gunnison, Uncompahgre and San Miguel Rivers. The Colorado River drainage basin bounds the district to the south, the official dividing line between the borders of Mesa and Pitkin Counties. The Continental Divide forms a natural boundary to the territory in the east with Chaffee County line as the agreed upon border. The State of Utah lines the region's western boundary.

Agriculture, mining and tourism form the economic base of Region 10. The North Fork area of Delta County is a major energy impact area for coal mining. There also are several sizeable food processing plants. The region's trade centers are Gunnison, Montrose and Delta. Approximately one-sixty of Colorado's federal land holdings are in the region. The wealth of recreational land provides ample facilities for hunting, fishing and skiing.

1. Existing Services

Midwestern Colorado Mental Health Center provides twelve essential mental health services, including a comprehensive partial care program and specialized programs for children and the elderly. The center has arrangements with three local hospitals to provide beds for psychiatric patients; some inpatients are sent to Colorado State Hospital. Transitional residential care is provided through contractual arrangements with local nursing and boarding homes. There are full-time staff members in Delta, Gunnison, Norwood and Montrose. Part-time service is provided in Telluride, Nucla, Crested Butte, Paonia and Ouray by staff traveling to these areas. Delivering service across this vast area necessitates

a sizeable travel budget. This, along with staff travel time, increases the per client cost. Midwestern is the only public mental health, family and marriage counseling agency in the catchment area.

The center currently has two federal grants which have enabled it to increase staffing and expand its services to more residents in previously underserved and unserved communities. The center has also received a federal construction grant for a new facility in Delta. As the federal grants decline, increased funding must come from fees, local and state sources if services are to be maintained at the current level.

2. Program Needs

There is need for more adequate psychiatric inpatient facilities within the catchment area in order to limit the number of patients sent to Colorado State Hospital. Other needs include an expanded high quality mental health program for alternate residential care facilities for adults, and further expansion of the partial care program.

REGIONS 11 & 12

(supercedes description in the basic plan)

Area: 23,386 square miles

Population: 146,022

Composition of Population:		
	Anglo	91.6%
	Asian	-0-
	Black	.3%
	Chicano	8 %
	Native American	.1%
	Other	-0-

1. Existing Services

Colorado West Regional Mental Health Center is the comprehensive mental health center which serves Regions 11 and 12. The center is comprised of a central administrative office in Glenwood Springs and four affiliates with subregional offices in the following communities: Grand Junction, Glenwood Springs, Granby and Steamboat Springs. In addition to providing full-time service in the above listed communities, full-time services are also available in Hayden, Eagle, Breckenridge, Aspen, Craig, Rangely, and Meeker. The affiliates provide outreach services on a regular basis in Dinosaur, Vail, Frisco, Minturn, Redcliff, Rifle, Oak Creek, Walden, Kremmling, Collbran and Fruita. Through these programs, service can be

delivered to small communities unable to support full-time clinics and thus make service available to persons unable to travel to larger centers. The decentralized programming approach has relied heavily upon community and staff involvement in designing services responsive to the widely diverse and unique needs of the many rural communities served. The services vary in emphasis from community to community, but a full range of services is available in the catchment area.

Fort Logan Mental Health Center provides state hospital inpatient services for children, adolescents, adults, alcoholics and geriatrics patients in Region 12. Region 11 receives these services from Colorado State Hospital.

The center has been remarkably effective in obtaining financial support from local governments and has also been successful in its pursuit of special funding to help deal with the mental health needs of the counties affected by the development of coal and oil shale resources.

2. Program Needs

Two primary service needs in this catchment area are additional local inpatient beds and non-hospital 24-hour care beds. The center has requested funding for these services. One impact of the availability of these services will be a reduction in inpatient admissions to Colorado State Hospital and a reduced average length of hospital stay.

REGION 13

Area: 3,715 square miles

Population: 48,321 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	87 %
	Asian	-0-
	Black	.8%
	Chicano	11 %
	Native American	.2%
	Other	1.0%

(No substantive changes have been made in the description.)

B. REVIEW PROCESS FOR CATCHMENT AREAS

(No substantive changes have been made in this section.)

C. RANKINGS OF CATCHMENT AREAS

(No substantive changes have been made in this procedure.)

LISTING OF CATCHMENT AGENCIES
IN RANKED ORDER
(supercedes rankings in basic plan)

Rank*	Agency
1	SE Colorado
2	SW Colorado
3	NW Denver
4	Midwestern
5	San Luis
6.5	Park East
6.5	West Central
8	Spanish Peaks
9	NE Colorado
10	Weld
11	Adams
12.5	Larimer
12.5	Colorado West
14.5	Pikes Peak
14.5	East Central
16.5	Bethesda
16.5	SW Denver
18.5	Boulder
18.5	Jeffco
20	Aurora
21	Arapahoe

*Rank of "1" indicates greatest need.

D. PROGRAM FOR DEVELOPMENT OF COMMUNITY MENTAL HEALTH RESOURCES

(This section is eliminated as the content has been incorporated into Chapter IV.)

E. FACILITIES

(No substantive cnanges have been made in this section.)

F. POVERTY AREAS
(added)

(For use in application for federal grants only.)

The catchment areas listed below qualify for poverty area designation, as each meets the following criteria set forth in Public Law 94-63 and related regulations:

"A poverty catchment area is a catchment area which has one or more subareas which are characterized as subareas of poverty. A subarea of poverty is one in which 15% or more of the population is in poverty. These subareas should constitute 35% or more of the catchment area's population."

These poverty designations are relevant only to the following types of federal grants: initial operations, consultation and education, facilities assistance.

Designated Poverty Catchment Areas

Region	Center/Clinic	Rank
8	San Luis Valley	1
10	Midwestern	2
6	SE Colorado	3
9	SW Colorado	4
1	NE Colorado	5
3f	NW Denver	6
5	East Central	7
2a	Weld	8
7	Spanish Peaks	9
2b	Larimer	10

APPENDICES

Appendix I

State Mental Health Advisory Council Information

- Roster
- Bylaws
- Minutes

State Mental Health Advisory Council Roster

COMPOSITION OF STATE MENTAL HEALTH ADVISORY COUNCIL

Name & Term* (# of years)	Sex: Female	Sex: Male	Ethnic Background: Asian Amer.	Ethnic Background: Black	Ethnic Background: Chicano	Ethnic Background: Native Amer.	Ethnic Background: White	Place of Residence	Type of Residence: Rural	Type of Residence: Urban	Type of Residence: Suburban	Class of Membership: Consumer	Class of Membership: Provider	Class of Membership: Nongov't Org.	Class of Membership: State Agency	Occupation & Type Of Employment
Magdaleno Avila (1)		X			X			Denver		X		X				Exec. Director, Colo. Migrant Council
Colleen Cook (1)	X						X	Denver			X		X			Director, Community Corporation
Richard Daetwiler (2)		X					X	Denver		X			X			Region III Alcohol & Drug Abuse Coord.
Lucy May Dame (1)	X						X	Denver		X		X				Chairman, Senior Citizen's Board
Dorothea Dolan (2)	X						X	Denver		X		X				Retired
Melanie Fairlamb (2)	X						X	(WS) Delta	X			X				Housewife
Peter Garcia (1)		X			X			Boulder			X		X			Boulder MHC - HSA Member
Carolyn Huber (1)	X						X	Denver		X		X				CMHC Volunteer
James Lauer (2)		X					X	Denver		X			X			Child Psychiatrist
Dolores Leone (1)	X						X	Denver			X				X	MH/MR Nursing Consultant-Health Dept.
Karen Litz (2)	X						X	Lakewood			X	X				Mental Health Association
Luis Medina (2)		X			X			(SE) Pueblo		X			X			Asst. Exec. Director-Spanish Peaks MHC
Pete Mirelez (2)		X			X			Adams County			X	X				County Commissioner - Adams
Josie Johnson (2)	X			X				Denver			X	X				Executive Assistant to Lieutenant Gov.
Herbert Pardes (2)		X					X	Denver		X					X	Professor & Chairman, Psychiatry, UCMC
Jack Quinn (1)		X					X	(SE) Pueblo		X		X				Exec. Dir.-Pueblo Housing Authority
Roger Richter (2)		X					X	Denver		X		X				Insurance and Real Estate
Steve Schmitz (1)		X					X	(WS) Rifle	X			X				Asst. Director, Colorado West CCG
James Syner (1)		X					X	Denver		X					X	Medical Consultant-Dpt. of Social Serv.
Marge Taniwaki (2)	X		X					Denver		X		X				Student
Clarence VanDeren (1)		X					X	Denver		X		X				Denver Area Labor Federation

*terms beginning September 1976

State Mental Health Advisory Council Bylaws

STATE MENTAL HEALTH ADVISORY COUNCIL

State of Colorado

BY-LAWS

ARTICLE I-NAME

The name of this organization shall be the State Mental Health Advisory Council of the State of Colorado.

ARTICLE II-PURPOSES & FUNCTION

The State Mental Health Advisory Council will function as an official advisory body to the Division of Mental Health concerning the development, revision and administration of the State Mental Health Plan. In that role, it will function as a collective voice for the mental health client, provider, planner, administrator and concerned citizen.

Among the Council's responsibilities are the following:

(a) The Council shall review the State Mental Health Plan each year to ascertain its relevance and responsiveness to changing mental health needs and to insure its coordination with other planning efforts. The Council shall make recommendations for changes and/or additions.

(b) The Council shall maintain a record of the dates of council meetings, issues considered and a record of actions taken, including specific reference to the required annual review of the State Mental Health Plan for inclusion in the annual up-date of the Plan.

(c) The Council shall serve as a standing committee of the State Health Coordinating Council with the approval of that body.

(d) The Council shall establish ad hoc groups for special assignments deemed necessary by the Council or the Director of the Division of Mental Health.

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State Mental Health Advisory Council
State of Colorado By-laws
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(e) The Council shall develop and maintain by-laws and appropriate operating guidelines to insure smooth and continous operation.

ARTICLE III-MEMBERSHIP

The State Mental Health Advisory Council shall consist of twenty-one members who will be residents of Colorado. Only nine members of the council shall be direct or indirect providers of mental health services. The membership shall include representatives of those elements of the mental helath service delivery system and the community which it serves, whose decisions impact the goals of:

(a) Health care cost containment.

(b) Access to health care services.

(c) Appropriate placement.

(d) Continuity of care.

The Council shall be appointed by the Governor. For the first year of the Council's existance, ten members shall be appointed for one year terms and eleven members for two year terms. From the second year forward, expired memberships shall be filled by the Governor for two year terms, except that appointments to fill unexpired terms of members who resign shall be for the unexpired terms of the resigned members. No Council member shall serve more than five consecutive years.

Any citizen may nominate persons to serve on the Council. The names of nominees may be submitted to the Governor, the Director, Division of Mental Health or the Council.

The selection process will be implemented in such a manner as to insure appropriate representation of the various geographic areas of the state, as well as the social econimic and ethnic groups residing in the state.

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page 3-continued

ARTICLE IV-OFFICERS

Each year the members of the Council will elect a Chairperson and Vice-Chairperson from the Council membership. A recording secretary may be designated by the Chairperson. The Chairperson and Vice-Chairperson shall be elected by the Council at its Annual Meeting.

ARTICLE V-MEETINGS

The Council shall meet regularly at least on a quarterly basis, the dates, times and places of which shall be set by the Council and reflected in the minutes of the regular meetings and any other such time as agreed upon by the Council. Meetings of the Council will be open to the public. The first regular meeting of the calendar year shall be known as the Annual Meeting.

ARTICLE VI-ATTENDANCE

Regular attendance by members is important. Members of the Council shall advise the Chairperson or designee in advance of non-attendance. A member who has three consecutive absences shall be requested to submit his/her resignation unless the Council, by majority vote, votes to allow the person to retain his/her membership.

There shall be no alternates designated to attend meetings in place of members.

ARTICLE VII-QUORUM

A quorum will consist of a majority of the members. With a quorum present at any Council meeting, a majority vote will decide all questions.

ARTICLE VIII-COMMITTEES

The Chairperson shall appoint as many standing and other committees as are necessary to carry on the work of the organization and membership in such committees may be composed of both members and non-members of this Council. The Chairpersons of such

committees must be members of the Council, however, and the Director of the Division of Mental Health shall be an ex-officio member of all committees.

One such standing committee shall be an Executive Committee which shall consist of the Council Chairperson, Vice-Chairperson and Chairperson of the Budget Committee plus at least two other Council members. This Committee shall meet as needed.

Another standing committee shall be the Budget Committee which shall consist of five or more members.

ARTICLE IX-STATE MENTAL HEALTH PLAN

The Council, at all times, shall operate under the scope of the State Mental Health Plan and follow its rules, guidelines and directives.

ARTICLE X-PARLIAMENTARY AUTHORITY

The rules contained in the "Robert's Rules of Order, revised" shall govern this Council and to all cases to which they are applicable and are consistent with these By-laws.

ARTICLE XI-AMMENDMENT OF BY-LAWS

These By-laws may be altered, amended or repealed and new By-laws be adopted by majority vote of Council Members at any regular meeting of the Council and following written notice to all members at least two weeks prior to such meeting. Such changes, however, shall be consistant with the authority granted the Council under the State Mental Health Plan.

Minutes of the State Mental Health Advisory Council

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: October 28, 1976
1:30-4:00 p.m.

PLACE: Division of Mental Health
Pavilion Conference Room

Committee Members Present:

Mr. Magdaleno Avila
Ms. Colleen Cook
Dr. Richard Daetwiler
Ms. Lucy May Dame
Ms. Dorothea Dolan
Ms. Melanie Fairlamb
Mr. Peter Garcia
Ms. Carolyn Huber
Jr. James Lauer
Ms. Dolores Leone
Mr. Luis Medina
Ms. Edna Mosley
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki

Absent:

Ms. Karen Litz
Mr. Pete Mirelez
Mr. Clarence VanDeren

Guests Present:

Dr. Capen Farmer
Mr. Armando Pollack
Ms. Elinor Stead
Mr. Lee White

Staff Present:

Dr. James Dolby
Dr. Raymond Leidig
Mr. Youlon Savage

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Dr. James Dolby, Director of the Division of Mental Health, opened the meeting welcoming the Council members and guests and expressed his appreciation of their interest. At the request of Dr. Dolby, Dr. Herbert Pardes, Chairman of the Department of Psychiatry of the University of Colorado Medical Center, acted as Chairperson for this meeting; and, upon agreement of the Council, will continue to do so until January when officers will be elected.

Dr. Dolby discussed the purpose of the Council as set forth in PL 94-63 and the implementing regulations. He also expressed his personal appreciation for the existence of the Council for purposes such as: a forum for input, a corporate body to formulate recommendations, a monitor of State Plan progress, State Plan input and a systematic, careful, thoughtful group to give the Division of Mental Health counsel through the years.

Mr. Lee White of the Governor's Office shared with the group that the Governor is extremely pleased that the members are participating in this function. He stated that there is often confusion as to who this type of council is to report to — in this instance, the Council is to work with the DMH, the key contact persons being Dr. Dolby and Mr. Savage. He urged the Council to be initiative-seeking and also to be consensual in their decision making process. This group represents the state and the mental health needs of the citizens of the state. Mr. White spoke briefly of the talk he delivered for Governor Lamm at the Alcohol, Drug Abuse and Mental Health Administration conference, a copy of which was distributed to Council members.

Dr. Dolby explained the organizational charts of the Department of Institutions and the Division of Mental Health (copies of which are included in Chapter II of the State Plan). Section B of Chapter II, which deals with membership, selection process and functions, responsibilities and procedures of the SMHAC was also reviewed, with the reference to the Council possibly serving as a standing committee of the State Health Coordinating Council (SHCC) (with approval of that body) being noted as very important. Upon request, Mr. Savage elaborated on this, explaining the SHCC's responsibility for development of the total health plan for the state, and the importance of mental health being included in this plan. The SHCC will not be formed until approximately January of 1977.

Discussion moved to a widely shared concern regarding the actual function of the Advisory Council. Members expressed their wish for worthwhile participation and to be heard. Dr. Pardes concluded the discussion with the comment that the opportunity for important contributions exists, and it is up to the Council to take advantage of it.

Mr. Savage reviewed the State Mental Health Plan chapter by chapter, pointing out key sections. The Plan has been reviewed by numerous agencies and organizations. The Plan should have been reviewed by the Council; however, the Plan had to be submitted in June, well before the Council was appointed. Some Council members did have an opportunity to make input into the final Plan through other agencies/organizations. The Standards for Mental Health Centers and Clinics, which will be a part of the State Plan, have undergone a public hearing, and are in the process of finalization by the Attorney General's Office and the Division. If there are any questions regarding the State Plan, members should contact Dr. Dolby or Mr. Savage.

Dr. Leidig spoke briefly to the group. He emphasized the importance of citizen input, and urged the group to focus on meaningful issues rather than getting caught-up in an interminable search for identity.

Roger Richter, Peter Garcia and Jim Syner volunteered to draft some by-laws for consideration.

The Council voted to use the State Fiscal Rules as the basis for reimbursement for travel associated with Council functions.

The Advisory Council requested a tour of some of the mental health facilities and participation in some on-site evaluations. (A schedule of on-site evaluations will be distributed to all members.) The possibility of holding meetings at different locations was also discussed. Members expressed interest in meeting with boards of the centers and clinics and with the Mental Health Association.

The Advisory Council will initially meet on a monthly basis. Members were requested to indicate in writing those days during the month when they cannot meet. An attempt will be made at the next meeting to set a regular meeting time.

The next meeting of the State Mental Health Advisory Council will be at Fort Logan Mental Health Center on Tuesday, November 23, from 2-4 p.m. in Room B-106. Possible agenda items include: base line figures used in the State Plan, budget and key DMH issues. Prior to this meeting, a tour of Fort Logan will be held from noon to 2 p.m. Members desiring to participate in the orientation and tour should meet in Room B-106.

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: November 23, 1976
2:00-4:00 p.m.

PLACE: Division of Mental Health
Conference Room B-106

Committee Members Present:

Ms. Colleen Cook
Ms. Judy Casados (for Mr. Avila)
Dr. Richard Daetwiler
Ms. Lucy May Dame
Ms. Dorothea Dolan
Mr. Peter Garcia
Ms. Carolyn Huber
Dr. James Lauer
Ms. Karen Litz
Ms. Dolores Leone
Dr. Luis Medina
Ms. Edna Mosley
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki
Mr. Clarence VanDeren

Absent:

Ms. Melanie Fairlamb
Mr. Pete Mirelez

Guests Present:

Dr. Capen Farmer
Mr. Ernest Ficco
Mr. Armando Pollack
Ms. Elinor Stead
Dr. Thomas Windham

Staff Present:

Dr. Robert Abelson
Mr. Dale Cunningham
Dr. James Dolby
Mr. Jerry Fransua
Dr. Sid Glassman
Mr. Tom Lewis
Mr. Paul Myers
Ms. Noel Nesbitt
Mr. Sam Reynolds
Mr. Youlon Savage
Mr. David Winfrey

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Dr. Pardes welcomed those in attendance and asked those not present at the previous meeting to introduce themselves.

Minutes of the October 28 meeting of the State Mental Health Advisory Council were approved as written and distributed.

Mr. Savage addressed the first agenda item, Baseline Figures Used in the State Plan, which was included on the agenda in response to a request of a Council member. A two-page document entitled "Baselines for State Plan Objectives Which Are Based on Changes in Workload" was distributed and explained by Mr. Savage. He noted that unless otherwise indicated, the objectives pertain to the total public mental health system.

Dr. Dolby introduced Noel Nesbitt, a Program Specialist on the DMH staff. Ms. Nesbitt's specialty area is Adult Alternate Living Facilities, which is a high DMH priority area for new funding. The thrust of this area of programming is the development of a series of alternative residential treatment facilities.

The facilities will be utilized by persons who do not need hospital care, but require ongoing care in a residential setting. A matrix of residential alternatives to inpatient care was distributed and explained by Ms. Nesbitt. (Copy enclosed) In response to Dr. Syner's question, Ms. Nesbitt explained that a narrative will be written for each cell in the matrix.

Ms. Nesbitt informed the Council that mental health standards for nursing homes are scheduled to be developed by the end of January. These standards will be appropriately included in the matrix developed by Ms. Nesbitt and her committee.

Dr. Lauer asked if a similar matrix will be prepared for children and adolescents. He was advised that Dr. Olson and Mr. Reynolds, DMH child and adolescent specialists, respectively, are in the process of determining the various residential treatment needs of children and adolescents and how these can best be met.

Mr. Lewis, DMH Associate Director for Administrative Services, gave the Council a brief explanation of the budgeting process, emphasizing that this process is a year-round activity. The two-page budget summary (distributed with October 28 minutes) was explained by Mr. Lewis.

Ms. Leone suggested that the Council form an ad hoc subcommittee to review the budget document in more detail. The members of this ad hoc budget review subcommittee are Lucy May Dame, Peter Garcia, Jim Lauer and Roger Richter.

The fourth agenda item was reviewed. Dr. Lauer suggested adding the general areas of psychiatry, psychology and social work (and presumably nursing) to the list of possible issues for discussion and/or presentation at future meetings.

Mr. Savage called attention to the memo in the Council members' packets regarding updating of the State Mental Health Plan. He encouraged Council members to review the Plan and provide input on the form provided. Council members were also reminded that they will be reviewing and analyzing the input received in respect to possible changes in the State Plan.

The next meeting of the State Mental Health Advisory Council will be on December 10 at Colorado State Hospital in Pueblo. The first part of the day will be devoted to a tour of CSH, beginning at 10:00 a.m.; the second part of the day will be set aside for a meeting of the SMHAC from 1-4 p.m. (Lunch will be provided for all members at 12:00.) Members were asked to let Ms. Oglesby know which portion they are interested in attending for purposes of coordinating transportation.

Future meetings of the State Mental Health Advisory Council will be held on the second Thursday of each month.

Sally Oglesby
Recording Secretary

Distribution:

SMHAC Members	Carol Barbeito	Steve Jordan
Executive Directors	John Bliss	Raymond Leidig
Board Presidents	Ernest Ficco	Elinor Stead
Board Contact Persons	Henry Frey	Lee White
John Aycrigg	Charles Meredith	Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: December 10, 1976
1:15-3:30 PM

PLACE: Colorado State Hospital

Committee Members Present:

Ms. Lucy May Dame
Ms. Dorothea Dolan
Mr. Peter Garcia
Dr. James Lauer
Ms. Karen Litz
Dr. Luis Medina
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Clarence VanDeren

Guest Present:

Dr. Ronald C. Werner

Staff Present:

Dr. James R. Dolby
Dr. Connie Olson
Mr. Sam Reynolds
Mr. Youlon D. Savage

Absent:

Mr. Magdaleno Avila
Ms. Colleen Cook
Dr. Richard Daetwiler
Ms. Melanie Fairlamb
Ms. Carolyn Huber
Ms. Dolores Leone
Mr. Pete Mirelez
Ms. Edna Mosley
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki

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Several Council members participated in a mini-tour and presentation of Colorado State Hospital from 10 AM-12 Noon.

1. Minutes: Dr. Pardes called the meeting to order. A motion was made that the minutes of the previous meeting be approved; the motion was seconded and carried.

2. Residential Child Care Facilities (RCCF): Dr. Connie Olson, Program Specialist in the area of children's services for the Division of Mental Health, presented background information on the study of RCCF's which was mandated by footnote 45 in this year's Long Bill. The mandate was that "By January 1, 1977, the Department of Social Services, Department of Institutions, and the Office of State Planning and Budgeting are to provide a report comparing cost and treatment effectiveness and program evaluation of residential programs with those at Fort Logan and Colorado State Hospital."

A task force was established with representatives from the three state departments and the RCCF's. The State Office of Planning & Budgeting (SOPB) assumed over-all responsibility for the study. There is some concern that the study will not be well-designed, and the misleading results could prove destructive to existing children's programs. Dr. Dolby recommended that SOPB contract with staff from the Department of Child Psychiatry at the University of Colorado Medical School. It is not known what action SOPB will take in respect to Dr. Dolby's recommendation.

A meeting was held this week between the designated departments and the Joint Budget Committee (JBC). Dr. Dolby again expressed his dissatisfaction with the methodology of the study. The Executive Director of SOPB maintains that the study will be done, and that it will be a "good" report. The JBC extended the deadline to March 1, 1977, with interim reports due between January and March.

Because of the significance of this study, the Council members discussed various ways they might assist in influencing the staff of SOPB to design and conduct the study in such a way as to ensure valid results. Dr. Pardes suggested the formation of an ad hoc committee to study the entire subject in depth and bring back a report and suggestions to the next meeting. Mr. Quinn made this motion, Mr. Garcia seconded, and motion carried. The subcommittee members are: Dr. Lauer who will chair the group (he asked that he be removed from the budget subcommittee), Ms. Litz, and Dr. Medina.

3. Child and Adolescent Mental Health Services: The presentation was postponed to the February meeting. However, Mr. Sam Reynolds, Program Specialist in the area of adolescent services, gave a brief outline of the Division's extensive involvement in child and adolescent services. Dr. Lauer commented that this was the first year that DMH has actively promoted children's and adolescents' services to this extent.

4. Review of Process for Establishing Goals and Objectives in the State Plan:

Postponed for a future meeting.

5. Presentation by Colorado Association of Community MH Centers & Clinics (CACMHCC):

Dr. Ronald C. Werner, Executive Director of the West Central Mental Health Center in Canon City, was introduced. He explained that CACMHCC is an organization of twenty-four community agencies which receive funding from the DMH. All but two of these facilities are private, non-profit corporations. CACMHCC is comprised of both professional and private citizen representatives of individual centers and clinics. The Association has an Executive Committee which includes representatives from the two state hospitals who are associate members. There are several functioning committees which have been actively working with staff of DMH on such matters as budgeting concerns, unit cost, and program evaluation. The organization has one part-time employee who is quite effective as a legislative consultant and representative. The Association is funded by membership dues which will be increased in the near future. There have also been grant awards from 314(d) funds for specific projects, one of which is a salary and classification study of centers and clinics.

While the Association is an independent corporation, it endeavors to work with DMH and others on a cooperative basis, and is systems oriented. At this point Dr. Pardes emphasized the concept of a "total mental health system" and mentioned the problems which can develop when one segment attempts to undermine another part of the system. This is an area which may require more attention. Dr. Werner stated he would carry this message back to the Association. He added this is one reason for having representatives from each of the state hospitals on their Executive Committee. Dr. Dolby stated that one of his great pleasures when he came to Colorado was to find that the Association was so active. The cooperation is about as good as could be hoped for, and the Association is a real ally to the Division.

Thanks was expressed to Dr. Werner for his comprehensive presentation.

6. Announcement: The Division of Mental Health will have its JBC hearing the afternoons of January 6 and 7, and these are open to the public. Council members will still have an opportunity for input into the budget process as negotiations take place.

According to Mr. Garcia, the budget subcommittee has not met yet, but will probably do so prior to the next meeting.

7. Next Meeting: The next meeting will be on January 13, 1976, in the Pavilion Conference Room (where the first meeting was held), second floor of the E Building, 4150 South Lowell Boulevard, Denver. Because of the extensive agenda, the members decided to convene at 1 PM rather than 2 PM and, if necessary, go later than the four o'clock schedule.

The agenda is as follows:
a) Report from subcommittee on RCCF Study
b) Report from budget subcommittee
c) Bylaws
d) Election of officers

Doris D. Davis
Recording Secretary

Distribution:
SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
John Aycrigg
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Robert Herrmann
Steve Jordan
Raymond Leidig
Elinor Stead
Lee White
Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: January 13, 1977
1-4 p.m.

PLACE: Division of Mental Health

Committee Members Present:

Dr. Richard Daetwiler
Ms. Dorothea Dolan
Ms. Melanie Fairlamb
Ms. Carolyn Huber
Dr. James Lauer
Ms. Dolores Leone
Ms. Karen Litz
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Ms. Marge Taniwaki
Mr. Clarence VanDeren

Guest:

Ms. Elinor Stead

Absent:

Mr. Magdaleno Avila
Ms. Colleen Cook
Ms. Lucy May Dame
Mr. Peter Garcia
Dr. Luis Medina
Mr. Pete Mirelez
Ms. Edna Mosley
Dr. James Syner

Staff Present:

Mr. Dale Cunningham
Dr. James Dolby
Mr. Tom Lewis
Mr. Youlon Savage

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Approval of Minutes - Dr. Pardes

The meeting was called to order by Dr. Pardes. The minutes of the December 10 meeting were approved as written.

Report of the Budget Subcommittee - Mr. Richter

The Budget Subcommittee felt that their role was unclear; as they view it, the primary purpose of this subcommittee is to make recommendations as to the Council's role in the DMH budget process and to carry out this role in the continuous budget cycle.

Because of the late establishment of this Council, they could not participate effectively in the budget process this year. However, the subcommittee did have the opportunity to review the material for the JBC presentation.

It was recommended by the Subcommittee that a standing budget committee be formed to function throughout the year, beginning at this time. This committee would be the most active section of the Council; it will require participation in the year round budget process.

Dr. Lauer asked for clarification of the Council's role in the fiscal area, in that involvement in the budget could be seen as going far beyond the State Plan. After some discussion, it was decided that the Budget Subcommittee is very relevant to the Plan, as the budget is a statement of the resources necessary to implement the Plan. A standing Budget Subcommittee will be formed. The committee will consist of the present members of the Subcommittee (Mr. Richter, Ms. Dame and Mr. Garcia) and two

additional Council members. Mr. Lewis will be the staff person assigned to the Subcommittee.

Mr. Richter will draft a letter to be sent to the Governor and the JBC expressing the Council's support of the 14.5 million dollar budget initially recommended by DMH. The letter will point out how the objectives in the State Plan relate to the 14.5 million. It was noted that the 14.5 million dollar budget is consistent with the recommendations of the Mental Health Association of Colorado and the Colorado Association of Community Mental Health Centers and Clinics. The second portion of the letter will address the Council's awareness and concern over the serious deficit which is developing in the Colorado State Hospital budget. Some causative factors are:

1. reduction in geriatrics inpatients;
2. over-estimation of third party income;
3. central collecting agency not successful in collecting bad debts;
4. accounting system changed from a cash basis to an accrual basis;
5. expected increase in Medicaid and Medicare rates did not occur.

The short-fall is $1,600,000; however adjustments will be made within the DMH which will reduce the supplemental request to around $800,000. The hearings on supplemental requests will be held at the end of January or the beginning of February. The presence of Council members is desirable.

DMH staff mentioned an important policy and budget request issue that the Council should be aware of: DMH is taking a risk in asking for an increase in funding only for community mental health centers and clinics, rather than in each of the state hospitals and the centers/clinics. The decision to request that all new state general funds for mental health services be appropriated for centers and clinics was based on the following assumptions:

1. that the practice of padding budgets is irresponsible management; and
2. that the budget request should relate directly to the State Plan; and
3. that since the main thrust of the State Plan is local availability of mental health services, new state dollars should be directed to meet the needs of high risk clients as close to their homes as possible; i.e., in community mental health centers and clinics; and that
4. the Joint Budget Committee and other members of the legislature are aware of the DMH's efforts to contain costs, follow a well-developed plan and otherwise exercise good management; and that
5. the pay-off for good management should be increased funding for needed services.

The increase sought by DMH is less than 5%.

Report of the Subcommittee on the Residential Child Care Facilities Study (Footnote 45) Dr. Lauer

Footnote 45 is an effort on the part of the JBC to obtain comparable information about the cost and effectiveness of children's services in the state hospitals and residential child care facilities (RCCF). Dr. Lauer summarized his Subcommittee's meeting with the State Office of Planning and Budgeting. Some highlights of the report are as follows:

1. The study has revealed the need for a better means of classifying children in need of mental health services;
2. Most child patients are placed on the basis of what facility is available rather than on the basis of the child's specific service needs;
3. The study has dramatically increased the cooperation and collaboration between the RCCFs and DMH;
4. Dr. Coppolillo of the University of Colorado Medical School has agreed to assist with the study, and has already initiated a contact with Fort Logan.

Dr. Lauer believes progress is being made. He will keep the Council apprised of new developments.

By-laws - Mr. Richter

The proposed by-laws for the State Mental Health Advisory Council were reviewed by the Council. They were adopted as changed by the Council. (An updated copy is being distributed to all members with the minutes. Additional copies of the by-laws are available at DMH.)

Election of Officers

The results of the election of officers is as follows:

Dr. Herbert Pardes - Chairperson
Mrs. Dorothea Dolan - Vice-Chairperson

Sally Oglesby will continue as the recording secretary. Roger Richter will serve as Chairperson of the Budget Subcommittee.

Update of the State Plan

Input to the update of the State Mental Health Plan is due by January 30. A timetable for completion of the update is being developed. Once the input has been assembled and organized by chapter, copies will be sent to SMHAC members. It was suggested that two Council members meet with the State Mental Health Plan Committee, which will be responsible for the actual updating of the Plan.

Next Meeting

The next meeting of the State Mental Health Advisory Council will be on February 10 from 1:30-3:30 p.m. at Fort Logan Conference Room B-108. (Agenda enclosed.)

Sally Oglesby
Recording Secretary

Distribution: SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Steve Jordan
Elinor Stead
John Aycrigg
Robert Herrmann
Raymond Leidig
Lee White
Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISO .OUNCIL

DATE: February 10, 1977
1:40-4:00

PL..CE: Division of Mental Health
B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Carolyn Huber
James Lauer
Dolores Leone
Karen Litz
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Marge Taniwaki
Clarence VanDeren

Absent:

Magdaleno Avila
Pet.. M .lez
Edna Mosley

Guests:

Sandy Farmer
Sophia Sanderson (for Mr. Avila)

Staff Present:

James Dolby
Pat Horton
Dick Noble
Sam Reynolds
Youlon Savage
Dave Winfrey

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Approval of Minutes: Dr. Pardes, Chairperson, called the meeting to order at 1:40 p.m. A motion was made and passed approving the minutes of the January 13 meeting.

Discussion of Relationship Between Division of Mental Health and Alcohol and Drug Abuse Division: Mr. Dave Winfrey, Substance Abuse Program Specialist of the DMH staff, gave a presentation on the relationship between DMH and ADAD. The letter of agreement between DMH and ADAD and the memo co-signed by Ken Kirkwood (Acting Director of ADAD) and Dr. Dolby to David Foote of the Human Services Policy Council (entitled, "Progress Report on Collaborative Efforts Between DMH and ADAD) were discussed. (These two items were distributed to Council members at the January meeting.)

A subcommittee was formed to take a closer look at the interface between DMH and ADAD as it relates to funding, services, monitoring, etc. The members of the subcommittee are:
Dolores Leone, Chairperson
Dorothea Dolan
Dick Daetwiler
Colleen Cook
Karen Litz

Mr. Winfrey will be available to the subcommittee as needed.

RCCF Study Update: Dr. Lauer reported that work continues on the attempt to develop a uniform classification system. When it reaches a useable stage, this system will probably be piloted in RCCFs.

Report of the Budget Subcommittee: Mr. Richter reported that the letters regarding the Council's stand on the budget requests were sent to the Governor and to the JBC. DMH and the subcommittee are prepared for a hearing on the CSH supplemental request. However, the hearing may not be necessary, as the Governor may use revenue sharing funds for the supplemental or the JBC may make a decision without a presentation by the Division.

Mr. Steve Schmitz will fill the vacancy on the Budget Subcommittee.

Continuation of Discussion on Children and Adolescents: Mr. Sam Reynolds, Adolescent Program Specialist of the DMH, continued his presentation which began at the December 10 meeting. This presentation consisted of review of the packet of material regarding child and adolescent services, which Council members received.

Ms. Dolan requested that data be obtained from the DMH statistical section as a means of determining how well the objectives in the State Plan are being met. This data will include the total number of admissions of children, adolescents and elderly, and the percent increase/decrease in admissions in FYs 75-76 and 76-77.

State Mental Health Plan Committee: The Council members who will work with the State Plan Committee and the areas they will review are as follows:

Peter Garcia - minorities	Dolores Leone - chapter on objectives
Jim Lauer - children/adolescents	Dorothea Dolan - priority listings
Lucy May Dame - geriatrics	Colleen Cook - total plan

The State Mental Health Plan Committee will begin meeting in a couple of weeks.

Executive Committee: The complete Executive Committee of the SMHAC consists of:

Herb Pardes
Dorothea Dolan
Melanie Fairlamb
Luis Medina

Items for Discussion at Future Meetings: The following items were suggested for discussion at future meetings:

Report of Alcohol & Drug Abuse Subcommittee
Feedback on State Plan
Data Requested from DMH
Status of State Health Coordinating Council
Presentation from the Mental Health Association

Next Meeting: The next meeting of the SMHAC will be held on March 10 from 1:30-4:00 p.m. at the Division of Mental Health Conference Room B-106. The entire meeting will be devoted to review of the State Plan. Members are requested to bring their individual copies of the Plan to this meeting.

Sally Ogesby
Recording Secretary

Distribution: SMHAC Members, Executive Directors, Board Presidents, Board Contact Person, Carol Barbeito, John Bliss, Ernest Ficco, Henry Frey, Steve Jordan, Elinor Stead, John Aycrigg, Haydee Kort, Raymond Leidig, Lee White, Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: March 11, 1977
1:45-3:30

PLACE: Division of Mental Health
B-106

Committee Members Present:

Dorothea Dolan
James Lauer
Herb Pardes, Chairman
Luis Medina

Staff Present:

Dale Cunningham
James Dolby
Sid Glassman
Sam Reynolds
Youlon Savage

Absent:

Magdaleno Avila
Colleen Cook
Richard Daetwiler
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Carolyn Huber
Dolores Leone
Karen Litz
Pete Mirelez
Edna Mosley
Jack Quinn
Steve Schmitz
Roger Richter
James Syner
Marge Taniwaki
Clarence VanDeren

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The meeting began at 1:45. The approval of minutes was deferred until the next meeting, since so few members were present.

Dr. Pardes gave a brief summary of the Senate HEWI Committee hearing on Senate Bill 221 (physicians' salaries). The general feeling was that the hearing went quite well.

Dr. Dolby updated the group on the legislative process of figure setting for the state hospitals and the centers/clinics. Although several figures have been considered, no definite decisions have been made. It is expected that the Long Bill will be out by the first of April. When we know the specific recommendations, we can decide what further action, if any, should be taken.

Pardes reviewed the report on the meeting involving representatives of the Handicapped Advisory Councils, which was sent to SMHAC members. It appears that the role of this group is very unclear. It was decided that further investigation should be made regarding the purpose of such a group before we decide if the SMHAC will be a participant.

Review of the State Plan was postponed until the next meeting, when the members of the State MH Plan Committee will be present to review suggested revisions of the State Plan. Council members will be mailed copies of the proposed update material prior to the next meeting.

The next meeting of the SMHAC will be on April 14 at the Division of Mental Health in Conference Romm B-108. The Alcohol and Drug Abuse Subcommittee will hold a meeting, before the Council meeting, at 12 noon in the Fort Logan cafeteria. (The last meeting was cancelled.)

Sally Oglesby
Recording Secretary

Distribution: SMHAC Members, Executive Dir., Board Pres., Board Contact, Carol Barbeito, John Bliss, Ernest Ficco, Henry Frey, Steve Jordan, Elinor Stead, John Aycrigg, Haydee Kort, Raymond Leidig, Lee White, Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: April 14, 1977
1:45-4:45 p.m.

PLACE: Division of Mental Health
B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Carolyn Huber
James Lauer
Karen Litz
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
Marge Taniwaki

Staff Present:

Bob Abelson
James Dolby
Sid Glassman
Paul Myers
Sam Reynolds
Al Sanchez
Youlon Savage
Fran Walker
Dave Winfrey

Absent:

Magdaleno Avila
Dolores Leone
Pete Mirelez
James Syner
Clarence VanDeren

Guests:

John Aycrigg
Richard Cripe
John DeHaan
Myles Edwards
Sandy Farmer
Ursula Garcia
Jerry Grossfeld
Bob Hawkins
Ernest Martinez
Floyd Martinez
Terry McGrann
Eugene Meeks
Larry Osaki
Robert Rabinowitz
Vicki Robbins
Elinor Stead
Phillip Swihart
Elaine Ulibarri
Chuck Vorwaller
Harry Walters
Fred Wells
Ron Werner

* * * * * * * *

The meeting was called to order at 1:45 p.m., and the minutes of the previous meeting were approved.

Dr. Dolby informed the group of the current budgetary situation. At the present time, there are five critical issues:

1. elimination of staff positions and reduction of budget in children and adolescent programs at Fort Logan
2. insufficient funds for sprinkler system at Fort Logan (could cause loss of accreditation for programs housed in affected buildings)
3. only 12.3 of the 13.5 million requested for centers/clinics has been recommended by the JBC. The way in which the funds are appropriated severely limits the DMH's flexibility in allocating the dollars.
4. insufficient funds for utilities at CSH
5. structural weakness in the Maximum Security Unit at CSH

In response to these issues, the Committee will send two letters: the first addressed to Members of the Colorado State Legislature urging reconsideration of above items 1, 2 and 3. The second addressed to Senator Strickland (Chairman, Senate Appropriations Committee) and Representative Herzberger (Chairman, House Appropriations Committee) calling attention to supplemental funding requests, above items 4 and 5. The first memo will be distributed Friday; the second, Monday.

Committee members were urged to speak personally with legislators regarding these matters.

Elinor Stead updated the Committee on what is currently happening at the legislature in regard to mental health funding.

The review of the draft of the update of the State Plan constituted the agenda for the last half of the meeting. Representatives of centers/clinics and voluntary agencies, such as Human Services, Inc. and Jewish Family and Children's Services, were also present to offer their input. A chapter by chapter review was begun with major emphasis on the objectives. Recommendations were made for additional objectives, alteration of existing objectives, etc. Mention was made of the need for stronger coordination between the public sector and the voluntary/private sector. In the final writing of the update, the Division will keep in mind the concern that the system is being driven beyond its capacity, and that while statewide priorities are necessary, agencies must have some latitude to address local needs. Council members and others were encouraged to use the forms developed by the Division to record their recommendations. The detailed review of the objectives and the balance of the Plan will be continued at the next meeting.

Ms. Fairlamb recommended that the review be continued at the next regular meeting to allow adequate time for Council members to individually review the document.

The next meeting of the State Mental Health Advisory Council will be held on May 12 from 1:30-4:30 p.m. in DMH Conference Room B-108. Since there is a large volume of material to be covered, the meeting will begin promptly at 1:30.

The Substance Abuse Subcommittee will meet at 12 noon in the Fort Logan cafeteria, prior to this Council meeting.

Sally Onjesby
Recording Secretary

Distribution:
SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
Carol Barbeito
John Bliss
Ernie Ficco
Henry Frey
Steve Jordan
Elinor Stead
John Aycrigg
Haydee Kort
Raymond Leidig
Maryellen Waggoner
Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: May 12, 1977
1:30-4:00 PM

PLACE: Division of Mental Health
B-108

Committee Members Present:

Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Carolyn Huber
James Lauer
Dolores Leone
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Clarence VanDeren

Absent:

Magdaleno Avila
Colleen Cook
Peter Garcia
Karen Litz
Pete Mirelez
Marge Taniwaki

Guests:

Sandy Farmer
Bob Hawkins
Paul Isenstadt
Earl McCoy
Larry Osaki
Elinor Stead
Maryellen Waggoner

Staff Present:

Bob Abelson
James Dolby
Sid Glassman
Connie Olson
Sam Reynolds
Al Sanchez
Youlon Savage

* * * * * * *

Dr. Pardes called the meeting to order. He announced that Ms. Mosley had resigned from the Council recently because of illness. Any recommendations for replacement should be made to the Governor.

Legislative Review: Dr. Dolby gave an update on the five budgetary issues listed at the last meeting: 1) he understands that funds have been reinstated for the children's and adolescents' program at Fort Logan; 2) funds for the Fort Logan sprinkler system are not in the Long Bill at this time; 3) there are no new funds for community programs - there are still the two categories: continuation and high risk; 4) there has been $100,000 restored for utilities at CSH, and hopefully the remainder will be forthcoming; 5) funds to secure the Forensic Unit at CSH are not in the bill at the present time. He stated that everyone's efforts in these funding requests have been well received. Dr. Pardes expressed appreciation to the staff, members of the Council, and to Ms. Stead.

Review of State Plan: The members continued their review of the Plan, starting with Goal #3. Discussion centered around some issues on children, adolescents, elderly, and rural residents. It was suggested that a statement at the beginning of Chapter III, such as a Preamble, be included to give an overall view about the development of resources, working with other agencies, availability of funds, and the matter of transportation. This would perhaps relieve some of the anxieties which have been expressed during the review process. Mr. Savage agreed that this would be done. He stated that the next step was a review by DMH staff in terms of the total input from the various organizations, etc., in preparation for the final document.

Next Meeting: June 9, 1977, 1:30-4:00 PM, Conference Room B-108.

The agenda is:
1. Drug and alcohol report
2. Discussion of two committees, corrections and minority
3. Site visit process
4. Council's program for year
5. Membership issues
   a. Absentee members
   b. Membership terms
6. Public education regarding support for mental health

Doris D. Davis
Recording Secretary

Distribution: SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
Carol Barbeito
John Bliss
Ernie Ficco
Henry Frey
Steve Jordan
Elinor Stead
John Aycrigg
Haydee Kort
Raymond Leidig
Maryellen Waggoner
Staff-DMH

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: June 10, 1977
1:30-4:00 p.m.

PLACE: Division of Mental Health
B-108

Committee Members Present:

Richard Daetwiler
Dorothea Dolan
Peter Garcia
Carolyn Huber
Josie Johnson
Dolores Leone
Karen Litz
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
Marge Taniwaki

Guests:

Sandy Farmer
Bob Hawkins

Absent:

Magdaleno Avila
Colleen Cook
Lucy May Dame
Melanie Fairlamb
James Lauer
Pete Mirelez
James Syner
Clarence VanDeren

Staff Present:

Dale Cunningham
James Dolby
Noel Nesbitt
Connie Olson
Sam Reynolds
Youlon Savage
Dave Winfrey

* * * * * * *

Dr. Pardes called the meeting to order and the minutes of the May 12 meeting were approved as written.

Dr. Pardes introduced Ms. Josie Johnson, a new Council member appointed to fill the vacancy left by Ms. Mosley. Ms. Johnson is the Executive Assistant to the Lieutenant Governor.

Ms. Leone, Chairperson of the Substance Abuse Subcommittee, summarized the minutes of their two meetings (minutes previously distributed to Council members). The Council reviewed the recommendations submitted by the Subcommittee. These recommendations were responded to favorably by the Council, and the Subcommittee was asked to begin implementation of their recommendations and make a progress report to the Council in approximately four months. Dr. Dolby invited all those interested to attend the monthly meetings between DMH and ADAD.

Formation of an ethnic minority mental health task force was discussed. It was recommended that the present Minority Mental Health Task Force (ad hoc committee to DMH) be the base for establishment of an ethnic minority standing committee to provide input to the Council concerning mental health needs of ethnic minorities. Ms. Litz urged that Council members and consumers be included in the composition of this subcommittee. Dr. Pardes will speak with Ms. Taniwaki about chairing this subcommittee.

Regarding the development of a subcommittee on corrections issues, it was decided that Dr. Aycrigg and someone from the Department of Corrections should visit with the Council to discuss the mental health service needs of persons in the corrections system, and ways of meeting these needs. A decision concerning possible action by the SMHAC will be made following the presentation.

The issue of absentee members was discussed. It was pointed out that Mr. Avila and Mr. Mirelez have three consecutive absences. In accordance with the bylaws of the Council, a letter will be sent to Mr. Avila and Mr. Mirelez requesting that they submit their resignations.

A request will be made to the Governor that all active members who were appointed for a one-year term and are willing to serve another term, be reappointed for a two-year term.

Mr. Savage briefly reviewed the policy on participation in on-site evaluations, a copy of which was distributed. Ms. Nesbitt discussed the Revised On-Site Evaluation Instrument (ROSEI II) which should be finalized for typing next week. This document was established in accordance with the Standards/Rules and Regulations for Mental Health Centers and Clinics. The document was sent to all centers/clinics for review, but little response has been received. Suggestions were made for continued improvement in the site visit process.

The Council sent a letter (drafted by Mr. Schmitz) to the Presidential Commission on Mental Health, endorsing five candidates (Roberto Quiroz, Karen Litz, Charles Vorwaller, George Bachik and Robert McKeown) for testimony before the Commission in Tucson on June 20.

Ms. Dolan informed the Council that she has been appointed to President Carter's Rural Task Panel. (She pointed out that President Carter prefers "task panel" to "task force".)

Public education to increase public support for adequate funding for mental health services was discussed. The structuring of a public education effort was assigned to the Budget Subcommittee, which will work in collaboration with DMH staff. Dr. Dolby mentioned that the Public Information Officer position has been abolished by the legislature as of July 1, 1977.

Suggestions for agenda items and activities from September on are as follows:

- presentation by the Mental Health Association
- visits to programs
- review of plans submitted by centers/clinics for services to children, adolescents and elderly
- review of partial report on the first quarter objectives
- review data reports ("Orchid Reports") in terms of the State Plan
- discuss 314(d) proposals
- review progress on Footnote 45 Study
- presentation on new federal mental health initiatives
- evaluation of Council's progress during its first year
- presentation on unit cost; its advantages and disadvantages
- review of Standards/Rules and Regulations for MH Centers and Clinics
- presentations from and discussions with representatives of the private and voluntary sectors

The next meeting of the State Mental Health Advisory Council will be held in conjunction with the Annual Mental Health Conference in Vail on Sept. 16, from 5-7:30 PM (tentatively). This date will take the place of the regular "second Thursday of the month" date this time only. Dr. Dolby will check into the possibility of funds from the Annual Mental Health Conference being used to supplement Council member's attendance. Mr. Schmitz and Ms. Fairlamb will arrange a social "get together" to provide an opportunity for Council members to mingle after the meeting. Mr. Winfrey, the DMH representative on the Executive Committee of the Conference, will be asked to assist in finding a site for the meeting and social function.

The agenda for this meeting will include discussion of the State Plan and the Budget.

The Substance Abuse Subcommittee will meet at 11:30, Thursday, August 11 at Fort Logan in Room A-200. Everyone is invited to attend.

Sally Oglesby
Recording Secretary

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John Aycrigg
Haydee Kort
Raymond Leidig
Staff - DMH

More information on the meeting place and social gathering will be forthcoming.

Appendix II

Report of the Colorado Chicano Mental Health Planning Symposium

COLORADO CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

Preliminary Summary of Proceedings

Colorado State Hospital
Pueblo, Colorado

March 25, 1977

Sponsored by

Chicano Symposium Committee
Mental Health Center of Boulder County, Inc.
Boulder, Colorado

Members of the Colorado Chicano Mental Health Planning Symposium met on Friday, March 25, 1977 at the Colorado State Hospital in Pueblo, Colorado. The purpose of the meeting was to discuss and agree on revisions to the State of Colorado Mental Health Plan '76 - '81 regarding goals and objectives for ethnic minorities, focusing on Chicanos. For this purpose the following persons attended the meeting:

Participant	City
Criselda Mondragon Cole	Denver
Grady Dale	Colorado Springs
Ed Espinoza	Pueblo
Ursula Garcia	Denver
Gregorio Kort, M.D.	Pueblo
Haydee Kort, M.D.	Pueblo
Anita Martinez	Boulder
Floyd H. Martinez, Ph.D.	Boulder
Richard Martinez	Cañon City
John Ortega	Pueblo
Roberto Quiroz	Pueblo
Mario R. Rodriguez	Florence
Albertino Salazar	Pueblo
Marguerite Salazar	Cañon City
Wayne Smyer	Pueblo
Elaine Ulibarri	Denver

Anita Martinez opened the symposium by welcoming the participants and asking them to introduce themselves and provide a brief statement

concerning their activities in the mental health field. Following the introductions, Ms. Martinez discussed the purpose of the meeting. She then introduced Dr. Haydee Kort, Superintendent of the Colorado State Hospital. Dr Kort reported that Dr. James R. Dolby, Director of the Division of Mental Health, was unable to attend the symposium because he had to attend legislative sessions in Denver to discuss issues relative to the state mental health budget. Dr. Kort related that Dr. Dolby regretted not being able to attend the meeting, but had emphasized that it was critical for the Chicano Symposium to provide input to the state Mental Health Plan by April 1, 1977.

Introduced next was Dr. Floyd Martinez who gave a brief historical background of the Chicano Symposium, and shared his views concerning the social climate existing today in American society in relation to the poor, disadvantaged, and minorities. Dr. Martinez then addressed the two major items in the Mental Health Plan which the group had met to discuss, revise, and update. The first item was Goal #3, part f, on page III.24 of the plan, dealing with the provision of mental health services to ethnic minorities; the second item was Appendix II of the plan, regarding the concerns of the Chicano Mental Health Planning Symposium.

Following protracted discussion, the group agreed to recommend to the Division of Mental Health (DMH) the establishment of a new goal under which objectives and sub-objectives would be listed in order of priority. The members felt strongly that the mental health concerns of ethnic minorities, which are included as one component of ten in Goal #3 of the present plan, needed to be elevated to a separate goal--Goal #6. Because of the tremendous needs within the minority groups, the participants agreed that a goal concerned only with "ethnic people of color" would identify this concern as requiring individual treatment. Of

course, this symposium would make recommendations specific only to the Chicano community.

Listed below is the recommended new goal; objectives and sub-objectives are arranged in order of priority, within the time frame for the accomplishment of each objective and sub-objective.

Goal #6

To insure provision and availability of special mental health services to ethnic people of color.

Chicano Objectives

1. DMH will assume the responsibility to maintain a continuing dialogue with representatives of the Chicano community through the following mechanisms:
   a. DMH will allocate a slot in its Master Plan Committee for a representative from the Chicano Mental Health Planning Symposium.
   b. Formalize the relationship between the Director of DMH and the Chicano Symposium such that regular meetings are held to exchange information and maintain the thrust of the Chicano plan.
   c. The liaison process will serve as the central mechanism by which the Chicano plan is translated into specific action by DMH with the help of outside groups.

   Priority time frame: As soon as possible; no later than July 1, 1977.

2 DMH will allocate funds for the establishment of one or more specialized Chicano mental health resource centers.

Priority time frame: July 1, 1977

3. DMH will build into the site evaluation format specific criteria for assessing the adequacy of services to Chicanos by community programs, clinics, and hospitals.
   a. Each center/clinic will comply or will demonstrate plans to comply with PL 94-63 pursuant to requirements for serving clients in their own language and cultural context, (Section 206, D).
   b. Each center/clinic will be required to demonstrate that its staff has the cultural sensitivity and linguistic skill to serve the Spanish-speaking population through a program that is outreach-oriented.
   c. Each center/clinic will be required to include training in services to Chicanos as part of its ongoing inservice training program.

   Priority time frame: FY '77-'78

4 The staff development program will continue to develop and apply a curriculum on Chicano services for staff development on a statewide basis.
   a. Each new model will explore services in a different modality with the aim of systematically investigating all of the essential services mandated by PL 94-63.

   Priority time frame: FY '77-'82

5. DMH will conduct a survey of each catchment area of the State of Colorado to gather descriptive information as to the kind of efforts extant serving/meeting the diverse needs of Chicano clients.
   a. mental health centers, clinics/hospitals staffing patterns
   b. client profile

c. community demographic characteristics

d. ethnic mix of governing boards

Priority time frame: January, 1978

6. Conduct a survey of programming efforts to serve the special needs of the Chicano client.
Priority time frame: January, 1978

7. By January 1, 1978, the DMH will be actively soliciting funds for special research and demonstration projects to determine special treatment needs of ethnic minorities and techniques for most effectively meeting these needs.
Priority time frame: January 1, 1978

8. DMH will update the talent bank of minority health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos. This group will develop a mechanism for the exchange of expert technical information in minority services, and make recommendations regarding programs to meet the special mental health needs of ethnic minority groups.
Priority time frame: January 1, 1978

9. In its 1978-79 budget request, the DMH will ask for state funds to establish at least one research and demonstration project in the state designed to test out an appropriate outpatient service model for Chicano clients. A similar effort will be made to secure federal funds.
Priority time frame: FY '78-'79

10. During fiscal year 1978-79, DMH will fully implement the research and development projects initiated under Phase 1 (FY '76-'77). Interpretation. It is understandable that the start-up time on such programs may straddle fiscal years and/or the procurement of federal funds is often a protracted process.

    a. Each project will have a well-designed evaluation component that will yield data on its effectiveness and efficiency.

    b. Close attention will be paid to the transportability of each model to other areas of the state.

    Priority time frame: FY '78-'79

11. In light of the disproportionate number of Chicanos in the Corrections system, DMH will initiate close program collaboration with Division of Corrections on behalf of Chicano clients.

    a. intramural programs

    b. community programs

    Priority time frame: FY '78-'79

12. The DMH will write into its budget request an amount sufficient to maintain research and development programs with state funds.

    a. DMH will request state funds to program for Spanish-speaking clients in their own language and cultural context in every catchment area with at least 5% Chicanos.

    Priority time frame: FY '78-'79

13 DMH state budget for '79-'80 will routinely request funds for services to the Spanish-speaking population in its own language and cultural context

Priority time frame: FY '79-'80

14. By July 1, 1980, information from the special research and demonstration projects for Chicanos will be reflected in the services provided by centers/clinics and hospitals.
Priority time frame: July 1, 1980

15. DMH will be instrumental in the development of three additional research and demonstration projects on alternative models for Chicano services.
    a. Each new model will explore services in a different modality with the aim of systematically investigating all of the essential services mandated by PL 94-63.
Priority time frame: FY '80-'81

16. By the end of FY '81-'82, every catchment area with 5% Chicano population will have developed the capacity to serve that population in its own language and cultural context.
Priority time frame: FY '81-'82

17. By 1981-82 DMH staffing pattern will reflect Chicano representation throughout all levels of administration.
Priority time frame: FY -81-'82

The meeting was adjourned at 4:45 p.m.

Note: Issues relating to other ethnic minorities (Blacks, Native Americans, Asian Americans) will be addressed in future meetings of their own.

Appendix III

Updated Need Rankings of the Catchment Areas

UPDATED NEED RANKINGS OF THE CATCHMENT AREAS

Catchment Area		Rank on Resources Inventory	Rank on Social Indicators	Weighted Score*	FINAL RANK
1	NE Colo	4	12	28	9
2a	Weld	11	9	29	10
2b	Larimer	9	14	37	12.5
3a	Adams	7	13	33	11
3b	Arapahoe	19	20	59	21
3c	Boulder	13	17	47	18.5
3d	Jeffco	5	21	47	18.5
3e	Bethesda	8	18	44	16.5
3f	NW Denver	15	1	17	3
3g	Park East	10	8	26	6.5
3h	SW Denver	14	15	44	16.5
3i	Aurora	16	16	48	20
4	Pikes Peak	18	11	40	14.5
5	E Central	2	19	40	14.5
6	SE Colo	1	4	9	1
7	Span Peaks	21	3	27	8
8	San Luis	20	2	24	5
9	SW Colo	3	5	13	2
10	Midwestern	6	6	18	4
11,12	Colo W	17	10	37	12.5
13	W Central	12	7	26	6.5

Weighted Score = Social Indicator Rank times 2, plus Inventory Rank

Appendix IV

Availability of Comprehensive Community Mental Health Services in the 21 Catchment Areas (per PL 94-63)

(1)AVAILABILITY OF COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES
IN THE 21 CATCHMENT AREAS (per PL 94-63)

Catchment Area and Agency		Region	HSA	inpatient	other (non-hosp) 24-hour care(2)	partial hospitalization	outpatient	24-hour emergency services	specialized serv for children	specialized serv for elderly	consultation & education (incl rape prevention)	assistance to courts & other public agencies (prescreening)	follow-up care	alcoholism services	drug abuse services
1	NE Colo	1	1		X	X	X	X	X	X	X	X	X	X	
2	Weld	2a	1	X	X	X	X	X	X	X	X	X	X	X	X
3	Larimer	2b	1	X	X	X	X	X	X	X	X	X	X	X	X
4	Adams	3a	1	X	X	X	X	X	X	X	X	X	X	X	
5	Arapahoe	3b	1	X	X	X	X	X			X	X	X	X	X
6	Boulder	3c	1	X	X	X	X	X	X	X	X	X	X	X	X
7	Jefferson	3d	1	X	X	X	X	X	X	X		X	X	X	
8	Bethesda	3e	1	X	X	X	X	X	X		X		X	X	
9	NW Denver	3f	1	X	X	X	X	X	X	X	X	X	X	X	X
10	Park East	3g	1	X	X	X	X	X			X	X	X	X	X
11	SW Denver	3h	1	X	X	X	X	X	X		X	X	X	X	X
12	Aurora	3i	1	X	X	X	X	X	X	X	X	X	X		
13	East Central	5	1		X		X		X		X		X	X	
14	Pikes Peak	4	2	X	X	X	X	X	X	X	X	X	X	X	X
15	SE Colorado	6	2				X	X							
16	Spanish Pks	7	2	X	X	X	X	X	X	X	X	X	X	X	X
17	San Luis	8	2			X	X	X	X	X	X	X	X	X	X
18	West Central	13	2	X			X	X	X	X	X	X	X	X	X
19	SW Colorado	9	3		X	X	X					X	X		X
20	Midwestern	10	3	X	X	X	X	X	X	X	X	X	X	X	X
21	Colo West	11-12	3	X	X	X	X	X	X	X	X	X	X	X	X

(1) The quantity and quality of the services vary widely from catchment area to catchment area, and are related to: available funding, location (i.e., urban, rural, suburban), demographic variables, local priorities and other factors.

(2) Includes transitional halfway house services

Appendix V

Inventory of Existing Facilities

INVENTORY OF EXISTING FACILITIES

A. PROCEDURES FOR THE FACILITIES INVENTORY

In December 1976, the Colorado Division of Mental Health conducted the second Inventory of Existing Facilities. Forms and instructions were distributed to the community agency recognized by the state as having responsibility for the given catchment area. These agencies collected the data for their catchments, completed the forms, and returned them to the State Division for compilation and analysis.

The form was designed to collect basic information according to NIMH Inventory definitions. The term used in Colorado for transitional/intermediate care is "other 24-hour care." This latter term appears on the form and in this discussion for clarity to Colorado planners.

The Inventory was also used to gather additional information on beds actually utilized by the catchment community agency and on beds needed.

From the information collected by catchment areas, most of the data from Colorado's two state hospitals (Colorado State Hospital and Fort Logan Mental Health Center) were deleted from the resources of the catchment areas in which they are located (7 and 3e, respectively). This was done because the majority of resources of the two hospitals are not in fact available to these two catchment areas; i.e. the hospitals serve an area much larger than just the two catchment areas in which they are located. The present procedure, however, does include those portions of the state hospital data which are used by catchment areas 7 and 3e, respectively, since these do represent resources available within the catchments. The remainder of state hospital data appear in a separate table, not identified with any particular catchment area(s).

Also, the data used in the present rankings exclude all resources related to those facilities which were optional in completion of the Inventory. These types were excluded to assure statewide comparability, since these facilities were reported on an optional basis.

B. INDICATORS: JUSTIFICATION AND WEIGHTING

From the completed forms, indicators were selected by the Division of Mental Health for ranking Colorado's catchment areas in terms of resources. General considerations in the selection of these indicators included availability and accessibility of care, actual resources utilized by or in coordination with the catchment agency, and local (government and private) initiative in providing care.

With these considerations in mind, the following indicators were selected:

1. number of acute inpatient beds per 100,000 population (weight = .25);
2. number of other 24-hour care beds per 100,000 population (weight = .50);
3. total number of beds (inpatient and other 24-hour) with ownership by local government or private nonprofit per 100,000 population (weight = .10);
4. number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population (weight = .75);
5. number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population (weight = .10).

All data used in the above rates were collected in December, 1976 by the statewide Inventory of Existing Facilities. Following are respective descriptions of these indicators and the rationale for their selection and weighting:

1. Number of acute inpatient beds per 100,000 population.

   This rate of non long-term beds, following Federal Inventory definitions, was selected on the basis that there would probably be beds in such facilities as general hospital psychiatric services, CMHC's, or the like, to which population in an area would have greater immediate access than to long-term inpatient beds.

   This rate is assigned a base weight of .25 from which the weights of the remaining four indicators are constructed.

2. Number of other 24-hour care beds per 100,000 population.

   One of the highest priorities of the Colorado Mental Health Plan is the local provision of alternatives to inpatient hospital care. Special programs to attend to this priority often employ other 24-hour care beds. Therefore, this measure of other 24-hour care beds within each catchment receives the higher weight of .50.

3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.

   This is a further refinement of the above bed-rate indicators with the additional qualification of ownership from the Inventory form. Long-term beds are included here under the assumption that with this ownership restriction, such beds would be used largely by catchment area residents.

An additional weight (.10) has been assigned because the two types of agencies here may be assumed to have the greatest accessibility and least restrictions for catchment area residents. Additionally, this rate provides an indication of local initiative and commitment for mental health services.

4. Number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population.

   This non-24-hour care personnel hours measure was selected on the basis that these treatment intensities are more readily accessible (i.e., where population in an area might first turn for services). Also, there are likely to be less personnel involved in nonpatient care activities than would be the case in 24-hour treatment intensities. Additionally, these intensities are generally closest to home and represent the least restrictive types of treatment. These data, from the Inventory forms, represent all staff providing or administering client care and exclude clerical and maintenance staff. Private practice hours are deleted, as this is an optional variable on the Inventory.

   Since it is assumed that non-24-hour care services may be more easily available than 24-hour beds to a population in an area both in terms of numbers of such services and general accessibility, this rate is given a higher weight (.75) than the above indicators.

5. Number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population.

This final indicator qualifies the previous rate by restricting ownership to local government or private nonprofit, for the identical reasons cited in the discussion to indicator 3 above. Thus, these resources receive a little extra weight (.10) than they did in indicator number 4 above.

C. RANKING PROCEDURES

The final ranking of catchment areas is derived by summing the weighted ranks on each of the five indicators:

Catchment Area's Final Weighted Score = $\sum w_i r_i$ where i ranges from 1 to 5, r_i is the area's rank on the i_{th} indicator, and w_i is that indicator's weight.

Therefore, a Catchment Area's Final Weighted Score = $.25r_1 + .50r_2 + .10r_3 + .75r_4 + .10r_5$.

The catchment areas are then ranked on the basis of their final scores. This final ranking serves as the prioritization of the catchment areas within the Survey of Mental Health Resources.

The following tables present:

a. Final Ranks (including last year's ranks)

b. Rankings on Resource Indicators and Final Weighted Scores

c. Resource Indicator Scores

d. Data for Computation of Resource Indicators

e. Regional Summary of Existing Facilities (Excluding Optional Agencies)

f. State Hospital Resources Not Assigned to Any Catchment Area

Inventory of Existing Facilities

FINAL RANKS

Catchment Area		Final Ranks*	Final Rank from 1976 State Plan*
1	NE Colo	4	6
2a	Weld	11	12
b	Larimer	9	13
3a	Adams	7	9.5
b	Arapahoe	19	16
c	Boulder	13	18
d	Jefferson	5	2
e	Bethesda	8	8
f	NW Denver	15	14
g	Park East	10	11
h	SW Denver	14	17
i	Aurora	16	4
4	Pikes Peak	18	20
5	E Central	2	3
6	SE Colo	1	1
7	Span Peaks	21	21
8	San Luis	20	19
9	SW Colo	3	9.5
10	Midwestern	6	7
11 & 12	Colo West	17	15
13	W Central	12	5

* The Rank 1 represents the highest need.

Inventory of Existing Facilities

Rankings on Resource Indicators

and

Final Weighted Scores

Catchment Area		Rankings on Indicators* 1	2	3	4	5	Final Weighted Scores
1	NE Colo	4	7	5	6	7	10.2
2a	Weld	15	19	10	7	8	20.3
b	Larimer	11	6	4	13.5	15	17.8
3a	Adams	4	8	6	9	9	13.3
b	Arapahoe	16	15	16	18	19	28.5
c	Boulder	13	14	13	12	14	22.0
d	Jefferson	9	13	7	1	1	10.3
e	Bethesda	17	9	20	8	4	17.2
f	NW Denver	18	2.5	11	20	20	23.9
g	Park East	21	5	19	10	12	18.4
h	SW Denver	8	10	9	17	18	22.5
i	Aurora	10	20	18	13.5	11	25.5
4	Pikes Peak	19	17	17	15	10	27.2
5	E Central	4	2.5	2	3	3	5.0
6	SE Colo	4	2.5	2	2	2	4.2
7	Span Peaks	20	21	21	19	17	33.6
8	San Luis	4	18	15	21	21	29.4
9	SW Colo	4	2.5	2	4	5	6.0
10	Midwestern	4	11	8	5	6	11.7
11 & 12	Colo West	12	16	12	16	16	25.8
13	W Central	14	12	14	11	13	20.5

* 1. Number of acute inpatient beds per 100,000 population.

2. Number of other 24-hour care beds per 100,000 population.

3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.

4. Number of weekly non-24-hour care personnel hours per 1,000 population.

5. Number of weekly non-24-hour care personnel hours in agencies with local government or private nonprofit ownership per 1,000 population.

Inventory of Existing Facilities

Resource Indicator Scores

Catchment Area		Indicators* 1	2	3	4	5
1	NE Colo	0	13.7	13.7	9.0	9.0
2a	Weld	15.9	56.7	29.2	10.4	10.4
b	Larimer	7.5	8.3	9.9	13.5	13.5
3a	Adams	0	18.1	18.1	10.6	10.6
b	Arapahoe	20.4	38.3	58.7	19.0	19.0
c	Boulder	8.2	33.0	33.0	12.8	12.4
d	Jefferson	5.7	31.6	25.0	2.8	2.4
e	Bethesda	27.9	21.3	97.0	10.5	6.0
f	NW Denver	35.3	0	31.4	36.1	36.1
g	Park East	82.3	4.1	86.4	11.7	11.7
h	SW Denver	3.1	24.7	25.7	16.8	16.1
i	Aurora	6.9	75.4	69.4	13.5	11.6
4	Pikes Peak	40.9	52.2	63.8	14.4	11.2
5	E Central	0	0	0	5.6	5.6
6	SE Colo	0	0	0	3.8	3.8
7	Span Peaks	47.8	101.4	139.3	23.4	15.8
8	San Luis	0	53.0	53.0	36.4	36.4
9	SW Colo	0	0	0	6.3	6.3
10	Midwestern	0	25.2	25.2	7.2	7.2
11 & 12	Colo W	7.8	43.5	32.1	15.0	15.0
13	W Central	11.0	26.4	37.4	12.3	12.3

* 1. Number of acute inpatient beds per 100,000 population.

2. Number of other 24-hour care beds per 100,000 population.

3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.

4. Number of weekly non-24-hour care personnel hours per 1,000 population.

5. Number of weekly non-24-hour care personnel hours in agencies with local government or private nonprofit ownership per 1,000 population.

Inventory of Existing Facilities

Data for Computation of Resource Indicators

Catchment Area		1976-77 Population	Resource Indicator Data* 1	2	3	4	5
1	NE Colo	65,780	0	9	9	590	590
2a	Weld	112,893	18	64	33	1172	1172
b	Larimer	120,636	9	10	12	1623	1623
3a	Adams	210,504	0	38	38	2230	2230
b	Arapahoe	156,768	32	60	92	2986	2986
c	Boulder	181,930	15	60	60	2322	2262
d	Jefferson	347,990	20	110	87	960	820
e	Bethesda	136,069	38	29	132	1425	815
f	NW Denver	181,371	64	0	57	6552	6552
g	Park East	121,485	100	5	105	1420	1420
h	SW Denver	97,164	3	24	25	1628	1562
i	Aurora	116,756	8	88	81	1578	1358
4	Pikes Peak	318,145	130	166	203	4584	3569
5	E Central	19,903	0	0	0	112	112
6	SE Colo	60,293	0	0	0	232	232
7	Span Peaks	152,855	73	155	213	3597	2418
8	San Luis	41,484	0	22	22	1509	1509
9	SW Colo	42,507	0	0	0	266	266
10	Midwestern	47,530	0	12	12	343	343
11 &12	Colo West	140,167	11	61	45	2105	2103
13	W Central	45,397	5	12	17	560	560

* 1. Number of acute inpatient beds.

2. Number of other 24-hour care beds.

3. Total number of beds with ownership by local government or private nonprofit.

4. Number of weekly non-24-hour care personnel hours.

5. Number of weekly non-24-hour care personnel hours in agencies with local government or private nonprofit ownership.

REGIONAL SUMMARY OF EXISTING FACILITIES
-EXCLUDING OPTIONAL AGENCIES-

Catchment Area	-Number of Beds- Inpt Acute	Inpt Long Term	Other 24-Hour	-Number of Personnel Weekly Hours- Inpt	Outpt	Partial	Emer	Oth-24	Total
1			9		490	36	64	441	1031
2a	18		64	508	998	134	40	711	2391
b	9		10	563	1063	330	230	286	2472
3a			38	60	1262	813	155	407	2697
b	32	84	60	2985	2114	555	317	1021	6992
c	15	15	60	1060	1605	403	314	1066	4448
d	20	23	110	375	747	97	116	372	1707
e	38	65	29	2584	987	276	162		4009
f	64			2980	4385	1280	887		9532
g	100		5	40	600	540	280		1330
h	3	2	24	514	1036	515	77	533	2675
i	8	9	88	280	1050	240	288	2916	4774
4	130	22	166	5170	2976	1232	376	2753	12507
5					112				112
6					232				232
7	73	30	155	6832	2512	857	228	1791	12220
8			22	5	1231	268	10	412	1926
9					266				266
10			12		225	91	27	107	450
11&12	11		61	38	1609	282	214	458	2601
13	5		12	80	300	120	140	80	720

Inventory of Existing Facilities

State Hospital Resources Not Assigned to Catchment Areas

Name & Address of Resource	Ownership of Facility	Type of Facility	NUMBER OF BEDS			Total	Mental Health Personnel Weekly Hours				
			Inpatient		Transitnl/ Intermed (Other 24-Hr Care)		Facility Based				
			Acute	Long Term			Inpatnt Treatmt	Outpatnt Treatmt	Partial Treatmt	Emergcy Care	Transitnl/ Intermed (Other 24-Hr Care)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Colorado State Hosp. 1600 W. 24th Street Pueblo, CO 81003	State	Psychiatric Hospital									
Psychiatric Clients			278	574	10	28189	26164	1344		441	240
Medical/Surgical service			15			964	500	400		64	
Ft. Logan Mental Health Center 3250 W. Oxford Denver, CO 80236	State	Psychiatric Hospital	46	125	92	8779	6093	503	517		1666

Appendix VII

Health Care Facility Standards for Persons with Mental Health Problems

HEALTH CARE FACILITY STANDARDS

FOR PERSONS WITH MENTAL HEALTH PROBLEMS

(proposed)

CONTENTS

I. GLOSSARY OF TERMS

The following glossary is intended to indicate the way in which the terms listed are used in these standards and not as general definitions of the terms.

DEPARTMENT — The Department means the Colorado Department of Institutions. Licensing authority is retained by the Colorado Department of Health.

DIRECT PROGRAM SERVICE — Direct program services are individual and/or group therapy programs, medication checks, and diagnostic evaluations.

FACILITY — A facility for persons with mental health problems, herein after called facility, means a health care facility licensed by the Department of Health with an identifiably independent unit or an entire health care facility that provides therapeutic programs to patients and which is monitored by the Department of Institutions on the basis of these standards to provide treatment to persons with mental health problems.

INDIRECT PROGRAM SERVICE — Indirect program service is all other planned activities for patients beside direct program service which have designed theraputic value.

MENTAL HEALTH WORKER — A mental health worker is a person who has at least an Associate of Arts Degree in helping or human services, specialized training and one year's experience in working with persons with mental health problems.

OCCUPATIONAL THERAPIST — An occupational therapist is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association.

PATIENT — A patient or a person with mental health problems means a person certified as mentally ill or a person identified as having a mental health problem.

PLAN — A plan is that document developed by the health care facility which is a written description of its program, facility and staffing for caring for patients and which conforms to these standards.

PROFESSIONAL PERSON — Professional person shall mean a person licensed to practice medicine in the State of Colorado or a psychologist licensed to practice in the State of Colorado.

PROGRAM — Mental health program, herein after called program, means a therapeutic program of services and/or functions designed, staffed and implemented by the facility for the purpose of meeting the specific needs of persons with mental health problems.

PROGRAM SUPERVISOR — The program supervisor is that individual on the full time staff of the health care facility who has the responsibility of supervising and coordinating the special program staff and of implementing the inservice training program. The program supervisor shall have at least a Bachelor's Degree in a human services field and two years of experience directly related to the job function. The program supervisor shall not be the facility's Administrator or Director of Nursing.

PSYCHIATRIC NURSE	A psychiatric nurse is a registered nurse who has a Master's Degree in psychiatric nursing or two years of experience in treating persons with mental health problems.
PSYCHIATRIC SOCIAL WORKER	A psychiatric social worker is a person who is licensed in applied psychotherapy.
PSYCHIATRIC TECHNICIAN	A psychiatric technician is a person who has graduated from an accredited psychiatric technician program and licensed by the Colorado State Board of Nursing.
PSYCHIATRIST	A psychiatrist is a person licensed to practice medicine in the State of Colorado who has completed the requirements for board eligibility in psychiatry.
PSYCHOLOGIST	A psychologist is a person who is certified by the State of Colorado as a psychologist.
STATE PATIENT	State patients are all patients who are referred to a facility by a State Institution and/or community mental health center or clinic; and/or any patient who is certified to a State Institution or community mental health center or clinic. State patients shall also include all patients who are at any time referred to a facility by a State Institution or community mental health center or clinic and who are not now under the care of a private psychiatrist, certified psychologist or a psychiatric social worker.
THERAPEUTIC RECREATION SPECIALIST	A therapeutic recreation specialist is a person who is registered or eligible for registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

II. STATEMENT OF INTENT

Each health facility providing care for patients with mental health problems shall provide a therapeutic milieu facilitating the patient's ability to cope with a social, emotional and physical disability to reestablish independence and to attain optimum functioning. Each patient shall have the opportunity to participate in a special disability program specific to his/her needs. These standards are adopted pursuant to CRS 1973, 27-10-128, 129, and are intended to be supplemental to all other existing standards for health care facilities.

III. PLAN APPROVAL

Each facility shall submit to the Department a written description of its plan. The Department shall review the plan and, if it determines that the plan meets the needs of the population group to be served, shall issue written approval of the plan. Each facility shall comply with all requirements of its approved plan. The plan shall be evaluated and the plan amended as necessary and resubmitted annually to the Department.

A. Requirements for Plan Approval

1. Individual components of the plan shall be designed and provided to improve adaptive functioning and develop a potential for placement in a less restrictive living environment. If the facility provides services to persons with mental health problems, the requirements of these standards shall be met.

2. In order to be eligible to receive state patients a facility must submit an application and a plan which meets all the requirements set forth in these standards. Such application and plan shall be submitted first to the mental health center or clinic which has responsibility for the catchment area in which the facility is located. The mental health center or clinic shall make on-site evaluation of the facility, application and plan and shall submit its comments to the Department of Institutions and the applicant within 30 days of receipt of application.

3. When the Department determines that the plan meets the standards, it shall provide written approval of the plan to the facility.

4. Within 45 days after written approval of the plan, there shall be an on-site visit by the Department or its designee to evaluate the appropriateness of the implementation of the plan.

5. Within 90 days of the effective date of these regulations, every mental health center or clinic in conjunction with facilities in its catchment area, after thorough investigation, shall inform the Department of all state patients residing in catchment area in skilled or intermediate nursing care facilities. Such information shall also contain the names and addresses of each such patient. Any facility refusing to cooperate in the provision of information pursuant to this paragraph shall be disapproved by the Department under these standards.

6. Within nine (9) months of the effective date, the responsible mental health center or clinic shall make arrangements for evaluation of the patients and shall effectuate the transfer of appropriate patients from non-approved facilities to approved facilities.

B. Plan Requirements

The plan submitted ot the Department for approval shall include:

1. The written philosophy of the overall program and its goals.
2. A description of the procedure for evaluation of program goals and objectives.
3. A description of the population group to be served including the following:
   a. Age (chronologic and developmental when applicable)
   b. Sex
   c. Physical characteristics
   d. Emotional characteristics
   e. Behavioral characteristics
   f. Psycological characteristics (testing and measurement)
4. Number of patients to be served.
5. Provision for identification of individual patient needs, i.e., individual patient assessments. Programs which include the combining of patient groups shall be appropriate to the group needs.
6. Provision for an initial evaluation and assessment by interdisciplinary facility staff in conjunction with the area mental health center or clinic of the psychological, medical, nursing, dietetic, social and physical needs of each patient admitted within seven days of admission.
7. Provision for required program components.
8. A plan for use of community resources.
9. Provision for transportation and supervision to community resources arranged in accordance with the needs and conditions of the patients.
10. A description of the method and frequency of evaluating patient progress.
11. An organizational chart for program services staff.
12. A description of interdisciplinary professional staff by discipline and hours provided per week.
13. An example of an average patient's day.
14. Inservice training programs in effect or planned to assist staff in the recognition and understanding of the emotional problems and social needs of patients and the means of making the appropriate response in relating to such needs. Available community resources and services to be used in training shall be identified. The plan shall include provision for at least monthly in-service training and documentation thereof.
15. Provision for sufficient accommodations, including dining, recreational and program areas to meet the needs of the program for patients.
16. Provision for indoor and outdoor areas designated for programs with appropriate equipment, apparatus, and adequate supplies which shall meet the needs of patients.

C. Required Program Components

A minimum of three hours per week of direct program service, and seven hours per week of indirect program shall be provided for each patient. Any exception must be documented in the patient's record and weekly notes.

The facility shall provide, at least, all the following program services. Individual programs shall be based on the specific needs identified through the patient assessment

1. Self help skills training, including:
   a. personal care - use of medications
   b. money management
   c. use of public transportation
   d. use of community resources
   e. behavior control, impulse control
   f. frustration tolerance
   g. mental health education
   h. physical fitness

2. Behavior control, impulse control
   a. behavior modification
   b. remotivation therapy
   c. patient government activity
   d. group counseling
   e. individual counseling

3. Interpersonal relationships, including:
   a. social counseling
   b. educational and recreational therapy
   c. socialization activity such as outings, dances, etc.

4. Prevocational separation services, including:
   a. homemaking
   b. work activities

5. Prerelease planning, including out-of-home placement.

6. Therapy
   a. individual
   b. group

D. Program Services Staffing

A program supervisor shall be on duty at least 40 hours per week.

In addition to the program director and nursing staff, each facility shall provide either through direct employment or through contractual arrangement, an interdisciplinary treatment team to develop and implement programs and to provide specific expertise to the program staff and/or provide direct patient service. The interdisciplinary team shall meet and consider each patient's treatment plan at least monthly.

The interdisciplinary treatment team shall represent at least one of each of the following categories. Every team shall have at least a psychiatrist or psychiatric nurse.

1. Psychologist, Psychiatrist, Psychiatric Social Worker
2. Psychiatric Technician, Mental Health Worker, Psychiatric Nurse
3. Occupational Therapist, Art Therapist, Dance Therapist, Recreation Therapist or Music Therapist

Each interdisciplinary treatment team member shall have a minimum of one year of experience or training in a mental health setting.

E. Compliance

1. The Department or its designee will evaluate all facilities pursuant to these regulations.

2. If the Department or its designee finds, after evaluation, that facility is not in compliance with these regulations, the Department or designee shall first, within forty-five (45) days of the review, notify the facility in writing of the specific items found to have been out of compliance.

3. The facility shall have thirty (30) days from the receipt of the notice of non-compliance in which to submit written data and/or a plan and schedule for achieving full compliance, with respect to the matter(s) not in compliance.

4. The Department or its designee, after reviewing the facility's written reply, may take action as follows:

    a. approve the proposed plan and schedule for achieving full compliance; or

    b. approve a modified plan and schedule for achieving full compliance; c

    c. upon approval of the Executive Director of the Department, revoke, suspend, annul, limit or modify the approval of the facility.

    In cases where the Department or its designee approves a proposed or modified plan and schedule for achieving full compliance, the Department or designee shall grant provisional approval for a period not to exceed ninety (90) days. A second provisional approval for a period not to exceed ninety (90) days may be granted if necessary, in the opinion of the Department or its designee, to achieve full compliance.

5. Upon a determination by the Department or its designee that the facility has failed to comply with its plan, the Department shall cause termination of referral of state patients to that facility and all appropriate state patients shall be moved to an approved facility.

6. Any referring facility which refers state patients to an unapproved facility shall itself be considered out of compliance.

F. Waiver

A waiver of the specific requirements of these regulations may be granted by the Executive Director of the Department of Institutions in accordance with this section.

1. It is the policy of the Department of Institutions that each facility shall comply in all respects with these regulations.

2. A waiver of these regulations shall be granted only upon a finding that the waiver would not adversely affect the health, safety and welfare of the patients and the further finding that application of the particular regulation would create a demonstrated financial hardship on the facility seeking the waiver. The duration of a waiver shall not exceed one year. However, a waiver may be renewed for a one-year period. The facility seeking the waiver has the burden of proof. Consideration will be given as to whether the intent of the particular regulation has been met.

3. Requests for waivers shall be submitted to the Department or its designee. The request shall contain a detailed description of the mental health services provided by the facility, the effect of the proposed waiver on the health, safety, and welfare of the patients, and the degree of financial hardship on the facility.

4. At the time of submission of each waiver requests, the facility shall be required to post notice of the request and a meaningful description of its substance in a conspicuous place on its premises. The Department or its designee shall hold no conference as described in paragraph 5 unless it has been preceded by such notice which shall be reasonably calculated to inform interested persons of the date, time and place of the conference.

5. The Department or its designee will set a date convenient to all parties for a conference to discuss the waiver request in detail. The meeting shall be conducted as an informal conference to disucss the nature of the waiver request and to exchange information concerning the factors to be considered in reviewing the request. The meeting shall be open to public attendance and participation. The facility Administrator, Program Supervisor or their designees shall attend the conference. The facility and the Department or its designee may be represented by counsel.

6. Unless additional time is required to make inspections or obtain additional information from the facility, the Department or its designee shall notify the facility, in writing, within thirty (30) days following the date of the conference of its recommendation upon the waiver request. Thereafter, with (10) days, the Executive Director of the Department shall make a final decision upon the waiver request. The decision of the Executive Director shall constitute "final agency action" of the Department of Institutions within the meaning of the Colorado Administrative Procedure Act.

IV. ADMINISTRATIVE POLICIES AND PROCEDURES

If the program in a facility is not appropriate to a patient's needs, the patient shall be referred to a facility providing the appropriate program. At least one discharge planning conference with participants from both facilities shall be held before transfer. This move shall not be made without consent of the patient or his/her legal guardian, if any. A signed copy of the consent shall be kept of file. Disputes concerning transfers shall be referred to the Department or its designee for resolution. Nothing in these regulations shall be construed to limit the freedom of any patient to be treated by a professional person and in a facility of his/her own choosing.

All patients' medication regimes shall be reviewed and approved at least monthly by a consulting psychiatrist. All medication regimes for patients whose condition shall be considered unstable shall be reviewed and approved at least weekly by a consulting psychiatrist.

V. RESTRAINT AND SECLUSION

Each facility shall develop and implement written staff procedures for managing 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 imminently dangerous to himself/herself or others. A facility may limit such determinations to licensed physicians, pursuant to its rules or procedures. Each facility desiring to use locked or lockable units shall also develop and implement written staff procedures specifying the patients for which such units are appropriate and the circumstances and procedures under which they may be used.

1. Physical restraint/seclusion may be used only on the express order of a professional person, except in an emergency situation.

2. In an emergency situation, only such physical restraint/seclusion as is reasonably necessary shall be used, and a professional person shall be notified as soon as possible. Any use of physical restraint/seclusion shall be justified and described in detail in the patient's record. A patient who is physically restrained/secluded shall be observed by staff not less than every thirty (30) minutes during the period of restraint/seclusion. Only upon the examination and order of a professional person may a patient be physically restrained/secluded in excess of four hours.

3. Physical restraint/seclusion procedures in excess of 24 hours shall require a new authorization by a professional person. Authorization shall be accomplished by a professional person at least every 24 hours.

4. Justification for physical restraint/seclusion procedures shall be described in the patient's record.

5. Those facilities which accept patients should have the capability to provide for physical restraint within their physical plants.

6. Unless specifically excluded by order of the professional person providing treatment to the patient, all patients including those in restraint/seclusion or in locked/lockable units shall have frequent access to exercise areas, including outdoor exercise when weather permits.

VI. PATIENT RECORDS

A. The Colorado Department of Institutions, Divison of Mental Health Standards/ Rules and Regulations for Community Mental Health Centers/Clincis shall be used as the overall charting guide.

B. There shall be a record for each patient containing sufficient information to justify a diagnosis, a treatment plan and a course of treatment.

C. The diagnosis, the treatment plan and any specific medical, psychological or psychiatric treatment shall be based on appropriate medical, psychological and psychiatric examinations.

D. Treatment plans and specific medical, psychological or psychiatric treatments shall be documented in the patient's record and signed by the responsible staff member.

E. Also to be documented in the patient's record are periodic examinations, orders for medical treatment, treatment therapies and monthly case evaluations signed by the responsible staff member.

G. The review by the responsible interdisciplinary team which assesses the treatment plan's effectiveness, the patient's status, and revises the plan as needed to maximize progress, shall be noted in the patient's record.

H. Decisions regarding the disposition of the patient shall be documented in the patient's record together with the use made of any and all resources for effecting the disposition.

I. The facility and the responsible professional person shall have the responsibility to ensure that all information obtained and records prepared shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in section J., below.

J. Such information and records may be disclosed only: (1) in communications between professional persons in the provision of services or appropriate referrals; (2) when the patient designates persons to whom information or records may be released, but if a patient 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 patient, except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney or other staff person to reveal information which has been given to him/her in confidence by members of a patient's family; (3) for claims on behalf of the patient for aid, insurance or medical assistance; (4) to appropriate courts; (5) to persons authorized by an order of court; (6) unless prohibited by law to qualified persons designated by the Department of Institutions for monitoring and evaluation the program.

K. Records shall be kept in a secure location which safeguards their confidentiality.

Appendix VII

Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill

Department of Institutions
4150 South Lowell Blvd.
Denver, Colorado 80236
Telephone 761-0220

DATE: March 21, 1977

TO: All Interested Persons

FROM: Raymond Leidig, M.D., Executive Director

SUBJECT: Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Pursuant to C.R.S. 1973, 27-10-101, et seq., as amended.

MEMORANDUM OF ADOPTION AND PUBLICATION

I hereby adopt and publish the attached regulations as emergency rules and as permanent rules, pursuant to C.R.S. 1973, 24-4-103, effective March 22, 1977. The opinion of the Attorney General concerning these regulations is also attached.

I find that immediate adoption of these regulations is imperatively necessary for the preservation of the public health, safety, and welfare in that the current emergency designation regulations expire on March 23, 1977, and continued implementation of the Act covering the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101, et seq., as amended, requires that designation regulations remain in effect continuously. Therefore, compliance with the notice requirements of C.R.S. 1973, 24-4-103 would be contrary to the public interest.

J.D. MacFarlane
Attorney General
Joan E. Dubofsky
Deputy Attorney General
Edward G. Donovan
Solicitor General

The State of Colorado

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
State Services Building
1525 Sherman Street
Denver, Colorado, 80202

March 21, 1977

Raymond Leidig, M.D.
Executive Director
Department of Institutions
4150 S. Lowell Blvd.
Denver, Colorado 80236

Re: Rules and Regulations of the Colorado Department of Institutions Concerning The Care and Treatment of the Mentally Ill, Adopted Pursuant to C.R.S. 1973, 27-10-101, et seq., As Amended. (IN MH BBNX)

Dear Dr. Leidig:

Pursuant to your request we have examined the above-referenced emergency and permanent rules and regulations adopted by the Department of Institutions pursuant to C.R.S. 1973, 27-10-101 et seq., as amended.

Pursuant to the State Administrative Procedure Act, particularly C.R.S. 1973, 24-4-103(8)(b), this office has reviewed the rules and regulations and finds that they are within the authority of the Department of Institutions to promulgate and, further, that there are no apparent constitutional or statutory deficiencies in their form or substance.

Authority for the promulgation of these rules is found in C.R.S. 1973, 27-10-105(1), 107(1)(c), 109(1)(c), 120(1)(d) as amended, and 126 as amended. Such authority necessitates the establishment of criteria by the executive director for designating and approving facilities providing 72-hour treatment and evaluation, short-term care and treatment, and long-term care and treatment. The Department of Institutions is required to adopt rules and regulations to enforce the Act in a consistent manner. C.R.S 1973, 27-10-126, as amended.

Your attention is directed to C.R.S. 1973, 24-4-103 which provides that the adopted rules must be approved by the Attorney General's office in regard to constitutionality and legality and that two copies of the Attorney General's opinion along with two copies of the adopted rules must be submitted to the Secretary of State. Also, you should

forward to the Secretary of State two copies of the "notice of public hearing" and the "memorandum of adoption." As provided in C.R.S. 1973, 24-4-103(8)(d), as amended, copies of all rules and regulations adopted or amended on or after July 1, 1976, and additional information related thereto should be submitted to the Legislative Drafting Office.

Therefore, you should immediately forward a copy of the rules and regulations as well as the notice and memorandum and this letter to the Legislative Drafting Office for referral to the appropriate legislative committee.

The Secretary of State has not established a Colorado regulations register, and, therefore, the publication referred to in C.R.S. 1973, 24-4-103(5) must be accomplished pursuant to the provisions of C.R.S. 1973, 24-4-103(11)(b), which provides that:

> Until the secretary of state has the facilities and funds and is fully prepared to publish each notice of rule-making and each rule as finally adopted and so notifies the agencies, each agency shall publish its own notices of rule-making and rules as finally adopted. Publication shall be by mailing a copy to each person on the agency's mailing list, which shall include the attorney general and every person who has requested to be placed thereon and who has paid any fee set by the agency for such purpose, such fee to approximate the cost of the mailing to such person, and by placing and keeping a copy on permanent file in the agency's office for inspection by any person during regular office hours.

Very truly yours,

J. D. MacFARLANE
Attorney General

JDM:JNdeR:mb

ADOPTED: March 21, 1977

EFFECTIVE: March 22, 1977

RULES AND REGULATIONS OF THE COLORADO DEPARTMENT OF INSTITUTIONS CONCERNING THE CARE AND TREATMENT OF THE MENTALLY ILL, ADOPTED PURSUANT TO C.R.S. 1973, 27-10-101, ET SEQ., AS AMENDED.

I.

STATEMENT OF POLICY, PURPOSE AND APPLICABILITY

A. APPLICABILITY OF THESE REGULATIONS; DENIAL, REVOCATION OR NONRENEWAL OF DESIGNATION.

All facilities designated hereunder as 72-hour treatment and evaluation facilities or as short and long-term treatment facilities, including those facilities specially designated, shall meet all of the applicable requirements hereof at all times. However, specially designated facilities may be excluded from the requirements hereof, in accordance with the terms of the special designation. Any designation may be denied, revoked or not renewed by the Executive Director of the Colorado Department of Institutions if a facility is found not to be in compliance herewith, pursuant to C.R.S. 1973, 24-4-104, as amended.

B. ADHERENCE TO STANDARDS.

Each designated facility shall strictly adhere to the standards, regulations and statutory requirements applicable

to that facility, such as standards of the Colorado Departments of Health and Institutions, and any other standards that may be applicable, such as those developed by Professional Standards Review Organizations and, when implemented, the "Health Care Facility Standards" of the Colorado Department of Institutions.

C. ADHERENCE TO STATUTORY REQUIREMENTS.

Each designated facility shall strictly adhere to all statutory requirements of the Act for the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101 et seq., as amended. All staff shall be fully informed and periodically reinformed regarding the provisions and requirements of the Act and these regulations.

II.

GENERAL POLICIES

A. ORGANIZATION.

There shall be a single identifiable organization responsible for the operation of any facility designated hereunder. There shall be a director responsible for discharging the duties and responsibilities of the designated facility. Duties and responsibilities shall be discharged directly by the designated facility or by contractual arrangement. The name of the director shall be posted within the designated facility and shall be available to any person.

B. SERVICES.

Private facilities designated hereunder shall provide, at a minimum, inpatient services. Community mental health centers or clinics shall provide services which conform to Colorado law (C.R.S. 1973, 27-1-201 et seq., as amended) and federal law (42 U.S.C. § 2681 et seq., as amended by P.L. 94-63). State hospitals shall provide services as provided by Colorado law (C.R.S. 1973, 27-13-101 et seq. and 27-15-101 et seq., as amended). Each designated facility shall establish and maintain written policies and procedures for coordinating, integrating and ensuring continuity of medical and mental health treatment services. All designated facilities shall have ready access, at all times, to a physician and to medical services.

C. EVALUATION, CARE AND TREATMENT.

Evaluation, care and treatment shall be provided in a nondiscriminatory manner by professional staff meeting the standards of the various professions. Evaluation and treatment shall be provided in the least restrictive setting possible, consistent with the patient's needs and safety. The reasons for the choice of setting shall be documented in the patient's record. During the entire treatment process, the patient shall enjoy the maximum amount of freedom consistent with his/her treatment needs, including but not limited to those rights set forth in C.R.S. 1973, 27-10-117, as

amended. The director of a designated facility shall maintain records detailing all treatment and evaluation provided. There shall be a monthly review and update of each treatment plan.

D. PREVIOUSLY ADJUDICATED PATIENTS.

Persons previously adjudicated under the provisions of the prior Colorado mental health commitment statute, C.R.S. 1973, 27-9-101 et seq., as amended, which was repealed effective July 1, 1975, were not restored to legal capacity and competency because of the Colorado Supreme Court's decision in Estate of Phillips v. State of Colorado, ___ P.2d ___, (1976), which declared C.R.S. 1973, 27-10-114, as amended in 1975, unconstitutional. However, should any such person require further mental health treatment, he/she shall be certified and/or treated under the provisions of C.R.S. 1973, 27-10-101 et seq., as amended.

E. EMERGENCY PROCEDURES.

Each designated facility shall 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 imminently dangerous to himself/herself or others. A facility may

limit such determinations to licensed physicians, pursuant to its rules or procedures.

1. Physical restraint/seclusion may be used only on the express order of a professional person, except in an emergency situation.

2. In an emergency situation, only such physical restraint/seclusion as is reasonably necessary shall be used. A professional person shall be notified as soon as possible in such cases. Any use of physical restraint/seclusion shall be justified and described in detail in the patient's record. A patient who is physically restrained/secluded shall be observed by staff not less than every thirty (30) minutes during the period of restraint/seclusion. Only upon the examination and order of a professional person may a patient be physically restrained/secluded in excess of four (4) hours.

3. Physical restraint/seclusion procedures in excess of twenty-four (24) hours shall require a new authorization by a professional person. Authorization shall be accomplished by a professional person at least every twenty-four (24) hours.

4. Justification for physical restraint/seclusion procedures shall be described in detail in the patient's record.

5. As a last resort, when dealing with a person who is an imminent danger to himself/herself or others or gravely disabled, who is being detained under the emergency provisions of C.R.S. 1973, 27-10-105, in a region where an appropriate

inpatient facility is not available, a jail may be used as a temporary placement facility. The peace officer or professional person who takes the person into custody shall contact the nearest designated facility within three hours of the initial detention of the person. Within twenty-four (24) hours, the nearest designated facility shall either accept the person for treatment and evaluation or place the person under the care of an appropriate 72-hour treatment and evaluation facility. Exceptions to this provision shall be justified and described in detail in the patient's record, and an account of each such exception shall be mailed by the nearest designated facility to the Division of Mental Health of the Colorado Department of Institutions within ten (10) days from the initial detention.

F. UNAUTHORIZED DEPARTURE.

Each designated facility shall be responsible for maintaining reasonable security capabilities to guard against the risk of unauthorized departure.

G. PATIENTS' RIGHTS.

Every patient receiving evaluation or treatment shall be furnished by the designated facility with a written copy of his/her rights, and a list of such rights (translated into Spanish or any other appropriate language) shall be posted prominently in all designated facilities.

H. RIGHT TO VOTE.

Every patient shall be given the opportunity to exercise his/her right to vote in primary and general elections. The director of each designated facility shall assist each patient in obtaining voter registration forms, applications for absentee ballots and absentee ballots and in complying with any other prerequisite for voting.

III.

CRITERIA FOR DESIGNATING & APPROVING 72-HOUR TREATMENT AND EVALUATION FACILITIES.

A. Except for special designations, which may be made by the Executive Director of the Department of Institutions or his/her designee, on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient, no facility shall be designated as a 72-hour treatment and evaluation facility unless it is: (1) a general hospital or a psychiatric hospital licensed by the Colorado Department of Health, or (2) a community mental health center or clinic under contract with the Colorado Department of Institutions.

B. Records shall be maintained which adequately reflect evaluation procedures and findings, as well as treatment administered, and which contain a discharge plan which adequately covers the continuing treatment needs of the patient.

C. A professional person shall be responsible for the evaluation of and treatment administered to each patient.

D. Evaluations shall be completed as soon as possible after admission. A designated 72-hour treatment and evaluation facility may detain a person for evaluation and treatment for a period not to exceed seventy-two (72) hours, excluding Saturdays, Sundays and holidays if evaluation and treatment services are not available at the facility on those days.

IV.

CRITERIA FOR DESIGNATING AND APPROVING SHORT AND LONG TERM TREATMENT FACILITIES

A. Except for special designations, which may be made by the Executive Director of the Department of Institutions or his/her designee on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient, no facility shall be designated as a short or long term treatment facility unless it is: (1) a general hospital or a psychiatric hospital licensed by the Colorado Department of Health, or (2) a community mental health center or clinic under contract with the Colorado Department of Institutions.

B. Every patient receiving treatment for mental illness by a designated short and long term treatment facility shall, no later than twenty-four (24) hours after admission to treatment be placed under the care of a professional

person employed by or under contract with the designated facility. The professional person may delegate any part of his/her duties, except as limited by statute or these regulations, but he/she shall remain responsible at all times for the quality of the mental health treatment administered to the patient. The professional person shall be specifically responsible for:

1. Formulating a written treatment plan tailored to the needs of each individual patient, with the maximum feasible participation of the patient, including any provision for restrictive confinement, documenting the diagnostic basis of the plan and the progress of the treatment, and revising the plan whenever appropriate. A psychiatrist shall formulate any provision of the plan providing for psychiatric medication. The professional person or consulting psychiatrist shall not be responsible for providing nonpsychiatric medical care, but shall be reasonably alert in recommending and facilitating access to proper medical care and shall be responsible for coordinating mental health treatment with any other medical treatment provided to the patient.

2. Personally evaluating the patient at least once a month for the purpose of reassessing the appropriateness and effectiveness of the mental health treatment in promoting the patient's highest possible level of independent functioning

and ascertaining the need for continuing the patient's involuntary status, medication or restrictive confinement.

3. Personally conducting an on-site case review and evaluation session, together with regular treatment personnel, at least once a month for each patient. Medication shall be reviewed at least once a month by a psychiatrist.

4. Formulating a plan for continuing contact with and involvement of family members or the development or encouragement of other support systems.

5. Assuring that the placement alternative selected is conducive to optimum restoration of the patient's mental and physical functioning, with due regard for the safety of the patient and those around him/her and the availability of placement alternatives.

6. Monitoring the mental health treatment process.

7. If a placement facility is used, assuring that a member of the staff of the placement facility is personally responsible on an individual case basis for the mental health treatment of the patient while in that facility, under the professional supervision of the responsible professional person.

8. Assuring that all personnel who participate regularly in the mental health treatment process are identified in the patient's record.

9. Whenever clinically indicated, assuring physician visits and medical appraisal and treatment.

10. Developing a discharge plan, including provision of adequate transitional, after-care and followup services appropriate to the individual patient, calculated so as to maximally reduce the likelihood of rehospitalization or return to restrictive confinement,

11. Assuring referral for and documenting the provision of adequate support services, including but not limited to housing, social services and vocational rehabilitation services, calculated so as to maximally reduce the likelihood of rehospitalization or return to restrictive confinement.

C. The designated facility shall be responsible for the care provided by the professional person as detailed in Section IVB above. In addition, the designated facility shall be responsible for:

1. Assuring a humane psychological and physical environment for each patient.

2. Providing or arranging for vocational rehabilitation and educational services, including tutoring or other educational services to all children and adolescents.

3. Establishing contractual relationships with placement facilities, as defined in these regulations, which allow for placement of patients certified to or under the care of the designated facility, including (a) adequate provision for in-service training of placement facility staff according to a plan approved and monitored by the designated facility, (b) direct case supervision by professional

persons employed by or under contract with the designated facility, (c) necessary availability and necessary supervision of placement facility staff and (d) adherence to these regulations and the "Health Care Facility Standards" promulgated by the Colorado Department of Institutions pursuant to C.R.S. 1973, 27-10-128 and 129, as amended, when implemented. All such contractual relationships and all original or supplemental agreements and amendments shall be promptly, but in no event more than ten (10) days after the effective date of the agreement or amendment, reduced to writing and forwarded to the Division of Mental Health of the Colorado Department of Institutions for review.

D. No patient shall be transferred to any facility other than to a placement facility under contract with the transferor designated facility unless and until adequate arrangements for care by the transferee facility have been documented, including at least one discharge planning conference with participants from both designated facilities, at least twenty-four (24) hours advance notice to the patient of the impending transfer and notice to any court which has previously considered or been notified of the case. Disputes concerning transfers, including any protest or appeal by or for the patient, shall be referred to the Division of Mental Health of the Colorado Department of Institutions for resolution. No patient who is in the custody of a designated facility shall be transferred to another designated

facility unless and until adequate arrangements have been made for the transfer of the custody of the patient to the transferee designated facility.

V.

CRITERIA FOR USE OF PLACEMENT FACILITIES

A. All public and private facilities which are licensed by the Colorado Department of Health as general hospitals, psychiatric hospitals, community clinics and emergency emergency centers, convalescent centers, nursing care facilities, intermediate health care facilities or residential facilities, or community mental health centers or clinics under contract in the Colorado Department of Institutions, are hereby approved for use as placement facilities under these regulations.

B. Facilities approved for use as placement facilities may be used by any designated 72-hour treatment and evaluation facility or any designated short-and long-term treatment facility, at its discretion under the provisions of these regulations, subject to the provisions of Section IVC3 hereof, in order to provide care and security to any person undergoing mental health evaluation or treatment. Designated facilities shall not place patients in a placement facility unless all of the provisions of these regulations are met and placement in such facility is required in order to meet

the clinical needs of the patient. When a placement facility is required, the least restrictive facility possible must be used, consistent with the clinical needs of the patient.

C. A jail or other detention facility may be used as a placement facility for 72-hour treatment and evaluation: (1) when the person undergoing treatment and evaluation is ordered confined to a jail by a court pending resolution of criminal charges pursuant to C.R.S. 1973, 27-10-123; (2) when the person is confined pursuant to arrest by a peace officer, pending filing of criminal charges, and the peace officer or responsible public officer refuses to release the person to a less restrictive setting; or (3) as a last resort, when no less restrictive setting is possible for evaluation and treatment, for a maximum of twenty-four (24) hours. See Section IIE5.

D. A community clinic and emergency center, a nursing care facility, an intermediate health care facility or a residential facility may be used as a placement facility for 72-hour treatment and evaluation only if the responsible professional person finds that the use of the facility will be particularly beneficial to the patient and the patient (1) is already located in the facility, or (2) has been located in the facility within the preceding six months or (3) has been under the care of the designated 72-hour treatment and evaluation facility for at least three months preceding the evaluation and treatment.

E. Nothing contained in these regulations shall be construed to limit in any way the ability and duty of a facility to treat or evaluate persons in the least restrictive setting possible, and unrestricted community placement and out-patient evaluation and treatment shall be the preferred alternative whenever possible consistent with the patient's needs and safety.

VI.

GUIDELINES FOR TREATMENT RECORD ENTRIES

A. The Colorado Department of Institutions, Division of Mental Health "Standards/Rules and Regulations for Mental Health Centers and Clinics" (1977), as amended, shall be used as the overall charting guide.

B. There shall be a record for each patient containing sufficient information to justify a diagnosis, a treatment plan and a course of treatment.

C. The diagnosis, the treatment plan and any specific medical, psychological or psychiatric treatment shall be based on appropriate medical, psychological and psychiatric examinations.

D. Treatment plans and specific medical, psychological or psychiatric treatments shall be documented in the patient's record and signed by the responsible staff members.

E. Also to be documented in the patient's record and signed by the responsible staff members are periodic examinations, orders for medical treatment, treatment therapies and monthly case evaluations signed by the responsible professional person.

F. Observations and communications about the specific treatment goals and the patient's treatment progress shall be entered in the patient's record on a current basis, not less than once a week.

G. A patient review by the responsible professional person which assesses the treatment plan's effectiveness, the patient's status and revises the plan as needed to maximize progress, shall be noted in the patient's record on a regular basis, not less than once a month.

H. Decisions regarding the disposition of the patient shall be documented in the patient's record together with the use made of any and all resources for effecting the disposition.

I. The designated facility and the responsible professional person shall have the responsibility to ensure that all information obtained and records prepared shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in Section VIJ, below.

J. Such information and records may be disclosed only: (1) in communications between qualified professional

persons in the provision of services or appropriate referrals; (2) when the patient designates persons to whom information or records may be released, but if a patient 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 patient, except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney or other staff person to reveal information which has been given to him/her in confidence by members of a patient's family; (3) for claims on behalf of the patient for aid, insurance or medical assistance; (4) to appropriate courts; or (5) to persons authorized by an order of court.

K. Records shall be kept in a secure location which safeguards their confidentiality.

VII.

GUIDELINES FOR CONSENT FOR "SPECIFIC THERAPIES"

A. "Specific therapies" shall be considered to include all therapies or surgical procedures which may entail a substantial or catastrophic risk. Surgery, electroshock treatment, use of experimental drugs or use of drugs in extraordinarily strong dosages are examples of "specific therapies" which fall into this category.

B. The reason for the contemplated use of any specific therapy shall be fully documented in the patient's treatment

record. Specific informed consent shall be sought from the patient. No consent shall be valid for more than thirty (30) days. If the patient cannot or will not consent, consent shall be sought from the patient's legal guardian, if any.

C. The patient, and any representative designated by him/her or acting in a legal capacity for him/her, shall be informed by the attending physician as to the anticipated benefits and the risks involved in any specific therapy.

D. If the patient or his/her legal guardian refuses to consent to any specific therapy, the patient shall be offered alternative treatment, if a suitable alternative exists. If an imminent danger to the patient's life or to the lives of others exists, because of the patient's condition, the patient's physician, in consultation with the director of the designated facility or his designee, may, after careful and informed deliberation under procedures to be adopted by each designated facility, order a specific therapy without consent. Surgery may only be authorized if an imminent danger to the patient's life exists.

VIII.

EMPLOYMENT OF PATIENTS AND COMPENSATION.

A. Work, including all labor, employment or jobs involving facility operation and maintenance or used as labor-saving devices which are of an economic benefit to the

facility shall be treated as work and shall be compensated according to applicable minimum wage or certified wage rates.

B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping such as making one's bed or policing one's area shall not be treated as work and shall not be compensated.

C. Patients shall not be forced in any way to perform work.

D. Training programs must comply with all applicable federal and Colorado laws.

E. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the patient's record.

F. Privileges or release from a designated facility shall not be conditioned upon the performance of work.

IX.

NOTIFICATION OF THE COLORADO DEPARTMENT OF INSTITUTIONS, DIVISION OF MENTAL HEALTH.

Each designated facility shall inform the Division of Mental Health of the Colorado Department of Institutions of any and all legal proceedings concerning the quality of the mental health treatment afforded to any patient or former patient, to which the facility or any of its employees is a

party, and copies of all complaints and writs issued in such proceedings shall be mailed to the Division's central office within ten (10) days of receipt by any designated facility or placement facility.

X.

APPLICATION PROCEDURE

A. Facilities seeking designation or redesignation hereunder shall apply annually to the Colorado Department of Institutions, Division of Mental Health. Those seeking redesignation shall apply at least forty-five (45) days prior to the expiration of the prior designation. All applications shall be made on forms specified by the Division of Mental Health. The Division of Mental Health shall recommend action to the Executive Director in accordance with its assessment of the facility's compliance with these regulations. Facilities making application for designation may be required to document treatment administered or any other aspect of their operations reasonably related to the application. Facilities may be required to submit and to consent to a plan and schedule for full compliance to correct any deficiencies found. Denial or non-renewal of designation may be appealed in accordance with Section IA hereof.

B. All facilities designated on Schedule A attached hereto shall be designated as both 72-hour treatment and evaluation facilities and short and long term treatment

facilities until July 1, 1977. An up-to-date list of all designated facilities and placement facilities shall be prepared by the Division of Mental Health whenever changes occur and shall be circulated to interested persons who request being placed on the mailing list.

XI.

ENFORCEMENT

A. The Division of Mental Health of the Department of Institutions shall, at least annually, evaluate all designated facilities. Evaluation of placement facilities may also be conducted yearly at the discretion of the Division, but such evaluation will be limited to those services which are provided pursuant to agreement with a designated facility.

B. If the Division of Mental Health finds, after evaluation, that a designated facility is not in compliance with these regulations, the Division shall first, within forty-five (45) days of the review, notify the designated facility in writing of the specific items found to have been out of compliance.

C. The designated facility shall have thirty (30) days from the receipt of the notice of non-compliance in which to submit written data and/or a plan and schedule for achieving full compliance, with respect to the matter(s) not in compliance.

D. The Division of Mental Health, after reviewing the designated facility's written reply, may take action as follows:

1. approve the proposed plan and schedule for achieving full compliance; or

2. approve a modified plan and schedule for achieving full compliance; or

3. upon approval of the Executive Director of the Department of Institutions, revoke, suspend, annul, limit or modify the designation of the facility, in accordance with Section 1A hereof.

In cases where the Division of Mental Health approves a proposed or modified plan and schedule for achieving full compliance, the Division shall grant provisional approval for a period not to exceed ninety (90) days. A second provisional approval for a period not to exceed ninety (90) days may be granted if necessary, in the opinion of the Division, to achieve full compliance.

XII.

WAIVER

A waiver of the specific requirements of these regulations may be granted by the Executive Director of the Department of Institutions upon the recommendation of the Division of Mental Health in accordance with this section.

A. It is the policy of the Department of Institutions and the Division of Mental Health that each designated facility shall comply in all respects with these regulations.

B. A waiver of these regulations shall be granted only upon a finding that the waiver would not adversely affect the health, safety and welfare of the patients and a further finding that application of the particular regulation would create a demonstrated financial hardship on the designated facility seeking the waiver. The duration of a waiver shall not exceed one year. However, waivers may be renewed for one-year periods. The designated facility seeking the waiver has the burden of proof. Consideration will be given as to whether the intent of the particular regulation has been met.

C. Where a designated facility provides mental health services through placement in a placement facility, and a waiver is sought for such services, the designated facility, and not the placement facility, shall request the waiver.

D. Requests for waivers shall be submitted to the Division of Mental Health, and shall be signed by the board president and the director of the designated facility. The request shall contain a detailed description of the mental health services provided by the designated facility, the effect of the proposed waiver on the health, safety, and welfare of the patients, and the degree of financial hardship on the designated facility.

E. At the time of submission of each waiver request, the designated facility shall be required to post notice of the request and a meaningful description of its substance in a conspicuous place on its premises. The Division of Mental Health shall hold no conference as described in paragraph F of this section unless it has been preceded by such notice which shall be reasonably calculated to inform interested persons of the date, time and place of the conference.

F. The Division of Mental Health will set a date convenient to all parties for a conference to discuss the waiver request in detail. The meeting shall be conducted as an informal conference to discuss the nature of the waiver request and to exchange information concerning the factors to be considered in reviewing the request. The meeting shall be open to public attendance and participation. The designated facility board president and director or their designees shall attend the conference. The designated facility and the Division of Mental Health may be represented by counsel.

G. Unless additional time is required to make inspections or obtain additional information from the designated facility, the Division of Mental Health shall notify the designated facility, in writing, within thirty (30) days following the date of the conference of its recommendation upon the waiver request. Thereafter, with ten (10) days, the Executive Director of the Department of Institutions

shall make a final decision upon the waiver request. The decision of the Executive Director shall constitute "final agency action" of the Department of Institutions within the meaning of the Colorado Administrative Procedure Act.

XIII.

DEFINITIONS

A. "Designated Facility" shall mean a facility designated under these regulations by the Executive Director of the Colorado Department of Institutions, either (1) as an 72-hour treatment and evaluation facility, pursuant to C.R.S. 1973, 27-10-105 and 106, or (2) as a short and long term treatment facility, pursuant to C.R.S. 1973, 27-10-107 and 109.

B. "Patient" shall mean a person admitted to mental health evaluation or treatment by a designated facility pursuant to C.R.S. 1973, 27-10-101 et seq.

C. "Placement Facility" shall mean a public or private facility which is 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 Colorado 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 the provisions of Sections IVC3 and V hereof. A jail may also be used as a placement facility pursuant to the provisions of Section IIE5 and VC hereof.

D. "Professional Person" shall mean a person licensed to practice medicine in the State of Colorado or a psychologist licensed to practice in the State of Colorado.

E. "Special Designation" shall mean designation of a facility as a 72-hour treatment and evaluation facility or a short and long term treatment facility by the Executive Director of the Colorado Department of Institutions or his/her designee, on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient. Special designations may or may not entail a waiver as provided in Section XII hereof, but special designations shall not be limited by the provisions thereof.

F. "Specific Therapy" shall mean any treatment which may entail a substantial or catastrophic risk, including major medical treatment in the nature of surgery, electroshock treatment, use of experimental drugs or use of drugs in extraordinarily strong dosages.

The following facilities are hereby designated as 72 Hour Treatment and Evaluation Facilities and Short and Long Term Treatment Facilities, pursuant to C.R.S. 1973, 27-10-105, 107 and 109:

1. Fort Logan Mental Health Center
2. Colorado State Hospital
3. Northeast Colorado Mental Health Clinic
4. Weld Mental Health Center
5. Adams County Mental Health Center
6. Arapahoe Mental Health Center
7. Bethesda Community Mental Health Center
8. Mental Health Center of Boulder County
9. Northwest Denver Mental Health Center
10. Jefferson County Mental Health Center
11. Southwest Denver Community Mental Health Center
12. Park East Comprehensive Mental Health Center
13. Pikes Peak Family Counseling and Mental Health Center
14. Spanish Peaks Mental Health Center
15. San Luis Valley Comprehensive Community Mental Health Center
16. Southwest Colorado Mental Health Center
17. Midwestern Colorado Mental Health Center
18. Colorado West Regional Mental Health Center
19. Larimer County Mental Health Center
20. West Central Mental Health Center
21. Aurora Mental Health Center
22. Veterans Administration Hospital, Denver, Colorado
23. Veterans Administration Hospital, Fort Lyons, Colorado
24. Emery John Brady Hospital

25. University of Colorado Medical Center
    Colorado General Hospital
    Colorado Psychiatric Hospital

26. Veterans Administration Hospital, Grand Junction, Colorado

27. St. Joseph's Hospital

28. St. Anthony's Hospital

29. St. Mary's Hospital, Grand Junction

30. Porter's Hospital

31. Boulder Psychiatric Institute

Appendix VIII

Report of Accomplishment of Objectives in 76-77 State Mental Health Plan

Status of
STATE PLAN OBJECTIVES
for
FIRST QUARTER
(July 1976 through October 1, 1976)

GOAL #1

a. By July 1, 1976, a uniform Chart of Accounts for the two state hospitals will be developed.

This objective has been accomplished.

b. By October 1, 1976, financial audit guidelines for centers/clinics will be developed.

Preliminary Financial Audit Guidelines for Centers/Clinics were established during August 1976; final audit guidelines will be issued on or before November 1, 1976.

f. By September 1, 1976, quarterly meetings with representatives of the State Health Planning and Development Agency will begin.

The State Health Planning and Development Agency (SHPDA) was not designated until recently. However, Division staff met with Health Department planners on September 24 to discuss coordination with SHPDA.

f. By September 1, 1976, quarterly meetings with the Department of Psychiatry, University of Colorado Medical Center will begin.

This objective was accomplished on September 15, 1976.

f. By September 1, 1976, quarterly meetings with the Department of Social Services will begin. These meetings will deal with such issues as reimbursement for mental health services under Titles XVIII, XIX and XX of the Social Security Act, and other aspects of care to persons eligible for services reimbursable by social service funds.

One informal meeting has been held, and there have been several telephone conversations with key people in the Division of Medical Services.

f. By October 1, 1976, DMH will begin providing the State Health Coordinating Council (SHCC) with information on mental health service needs and recommended programs for meeting these needs on an annual basis.

The SHCC will not be formed until about January 1977.

g. By October 1, 1976, DMH will produce a catalog of programs offered by its agencies.

This has been accomplished.

g. By October 1, 1976, a methodology for performing a comprehensive need assessment will be decided upon.

A need assessment to estimate the number and locations of severely disturbed individuals in Colorado is under way. This is the first stage of the need assessment study. The methodology for this first stage is currently being worked out with the Need Assessment Task Force.

GOAL #2

d. By July 1, 1976, a continuing education grant will have been developed for the training of center/clinic staff in the provision of services required by PL 94-63 (inpatient, outpatient, partial care, consultation and education, emergency, prescreening, follow-up, halfway house services and services to children, the elderly and substance abusers).

This has been accomplished and the grant has been approved and funded.

d. By October 1, 1976, DMH will begin providing training to mental health agencies in the delivery of consultation services to other caregiving agencies.

This will be accomplished under the auspices of our new continuing education grant in the second or third quarter of this fiscal year.

GOAL #3

c. By September 1, 1976, DMH will begin holding at least quarterly meetings with the Division of Services for the Aging with specific attention to the requirements and guidelines included in PL 94-63, the Community Mental Health Center Amendments of 1975, the Older Americans Act, and other federal and state statutes and directives which relate to services to the elderly.

The first quarterly meeting was held on September 1.

c. By September 1, 1976, DMH and the Division of Services for the Aging will begin actively promoting a statewide field-level partnership between community mental health centers/clinics and area aging agencies with a view toward including a mental health services component in the information and referral systems of the area aging agencies, and coordinating local assessments of program needs as they relate to the elderly.

This matter was addressed in the first meeting with the Division of Services for the Aging (DSA). DMH and DSA are working on an implementation procedure.

d. By August 1, 1976, the DMH and DADA will have established a work group to address the problems in coordinated service delivery identified by each Division.

The initial work group, comprised of DADA and DMH staff, has met on two occasions. The agenda for the third meeting will include a discussion of the expansion of the group to include representatives of other agencies and organizations.

d. By September 1, 1976, DMH and DADA will have entered into an agreement concerning coordinated on-site evaluations of alcohol and drug abuse programs at mental health centers, clinics and hospitals.

This objective has been accomplished.

d. By September 1, 1976, DMH and DADA will have coordinated procedures for the use of admission forms and program data.

This objective has been accomplished.

d. By October 1, 1976, DADA will have developed, in collaboration with DMH, a process for insuring input into the state alcohol and drug abuse plan by mental health centers and clinics, the two state hospitals, the DMH central office, and vice versa.

DADA has developed a procedure where they actively seek mental health input into their planning process. Copies of the drafts of their plans are distributed in advance to appropriate individuals within the Division of Mental Health, and also the persons designated by the Centers and Clinics Association.

h. By July 1, 1976, the DMH will use poverty as a major criteria for setting priorities for funding mental health agencies in Colorado.

This has been accomplished. A poverty factor is incorporated in the rankings set forth in the State Plan.

h. By October 1, 1976, all centers/clinics will be required to identify and prioritize the areas of poverty in their catchment areas and to indicate the efforts made and plans to serve these high risk populations.

This has been accomplished by way of the budget request documents for FY 77-78.

h. By October 1, 1976, DMH staff will begin meeting with appropriate State Department of Social Services and Regional DHEW staff to explore means of increasing the availability of funding (via Medicare, Medicaid and other Social Service programs) for mental health services to the poor. The results of these meetings will be appropriately disseminated.

One informal meeting has been held, and there have been several telephone conversations with key staff in the Division of Medical Assistance.

GOAL #4

1. By July 1, 1976, DMH central office will issue monthly releases to the media on various mental health issues.

This objective has been accomplished.

2. By July 1, 1976, the DMH will begin to offer consultation to one mental health agency per month on various ways of reaching the public.

This objective has been accomplished.

GOAL #5

1. By October 1, 1976, the DMH will offer periodic consultation services to Department of Health divisions (e.g., family health services, community health services, alcohol and drug abuse) which request such services.

   This objective has been accomplished with the Division of Alcohol and Drug Abuse.

   A request for review and comment on a document from the Community Health Services Division regarding the community mental health services section of their manual received immediate attention.

Status of
STATE PLAN OBJECTIVES
for
SECOND QUARTER
(October 1, 1976 through January 1, 1977)

* Indicates written reports or other written materials are available

GOAL #1

a. By January 1, 1977, a uniform cost allocation procedure (to include cost definitions and detail methods of allocation of all fixed, variable, and step variable costs) for the two state hospitals will be developed and implemented.

Completion date extended to 3-30-77.

*b. By October 1, 1976, financial audit guidelines for centers/clinics will be developed.

This objective has been accomplished.

*f. Quarterly meeting with representatives of the State Health Planning and Development Agency.

Second quarter meeting held on 11-10-76.

f. Quarterly meeting with the Department of Psychiatry, University of Colorado Medical Center.

Second quarterly meeting held on 11-19-76.

*f. Quarterly meeting with the Department of Social Services.

A total of 30 meetings were held during the second quarter.

f. By October 1, 1976, DMH will begin providing the State Health Coordinating Council (SHCC) with information on mental health service needs and recommended programs for meeting these needs on an annual basis.

The SHCC has not yet been appointed by the Governor.

*f. By November 1, 1976, periodic contacts will be established with the Department of Education and the Judicial Department to deal with areas of mutual concern, such as services to children and forensic issues.

There were 11 contacts with the Department of Education during the second quarter. There were no contacts with the Judicial Department, but eight contacts with various courts during this period.

*f. By January 1, 1977, periodic contacts with such divisions of the Department of Health as family health services, community health services, administrative services, alcohol and drug abuse and health facilities will be initiated.

Two scheduled joint DMH/ADAD meetings were held. One meeting was held with the Acting Assistant Director of the Office of Medical Care Regulation and Development. Two meetings have been held with State Health Planning and Development Agency staff. One meeting was held with the Division of Vital Statistics.

*g. By October 1, 1976, a methodology for performing a comprehensive need assessment will be decided upon.

The following has replaced the original objective:

By December 1, 1976, a preliminary need assessment study which estimates the number of "very disturbed people" in Colorado will be completed.

This objective has been accomplished.

GOAL #2

*b. By January 1, 1977, the Division of Mental Health will form a joint center/clinic-hospital treatment planning group to formulate diagnostic, admission, treatment and discharge policies.

State Hospital Continuity of Care Committees have been formed and are operational in both state hospital service areas.

d. By October 1, 1976, the DMH will begin providing training to mental health agencies in the delivery of consultation services to other caregiving agencies.

The initial workshop on consultation for mental health centers and clinics will be held in June 1977.

*d. By January 1, 1977, the DMH will have a proposed training program for increasing staff sensitivity to Chicano mental health needs.

The training program is currently being developed by the Minority Task Force.

d. By January 1, 1977, the Division of Mental Health will designate for development one or more specialized, mental health resource centers for educational materials which would be available to all mental health agencies. The resource center will include special sections for educational materials on Chicanos and other groups with special mental health service needs.

The libraries of Colorado State Hospital and Fort Logan MHC will be designated the initial mental health resource centers for educational materials on Chicanos and other minorities. This designation will be accomplished by March 30, 1977.

GOAL #3

*c. Quarterly meeting with the Division of Services for the Aging.

Three scheduled meetings between DMH and the Division of Services for the Aging have been held during the second quarter.

c. By January 1, 1977, the DMH will have begun to discuss with the Division of Services for the Aging ways of reflecting in the FY 77-78 budget of both Divisions their joint efforts to assist older persons in maintaining themselves in independent living arrangements.

This objective has been accomplished

*d. By January 1, 1977, the DADA-DMH work group will present a report to the Human Services Policy Council and the State Health Coordinating Council on the proposed procedures and mechanisms for overcoming problems in coordinated service delivery.

This objective has been accomplished.

*f. By January 1, 1977, the DMH will form a talent bank of minority mental health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos, Blacks, Native Americans and Asian Americans. This group will develop a mechanism for the exchange of expert technical information in minority services, and make recommendations regarding programs to meet the special mental health needs of ethnic minority groups.

Extension of time to March 15, 1977, approved by Director, Division of Mental Health.

*f. By January 1, 1977, the DMH will be actively soliciting funds for special research and demonstration projects to determine special treatment needs of ethnic minorities and techniques for most effectively meeting these needs.

This objective has been accomplished. Funds were obtained for curanderismo training program and workshop on the Chicano elderly. Additional funds are being sought through ADAMHA.

*f. By January 1, 1977, the DMH will conduct a study of the staffing pattern of each center/clinic to determine how these correlate with the ethnic and sex proportions in the client and general population.

The salary and classification survey is tentatively scheduled for completion in May 1977. Information on ethnicity and sex will be available when study is completed.

*h. DMH staff meeting with appropriate State Department of Social Services and Regional Department of Health, Education and Welfare staff to explore means of increasing the availability of funding for mental health services to the poor. The results of these meetings will be appropriately disseminated.

Meeting with DSS and DHEW held on 11-18-76 and 2-16-77, respectively.

i. By January 1, 1977, the DMH will form an ad hoc committee to gather information relating to mental health service needs of women and ways of effectively meeting these needs. This information will be disseminated to centers/clinics and hospitals.

Responsibility for accomplishment of this objective has been reassigned. A new target date of 7-1-77 has been set.

*j. By January 1, 1977, each catchment area agency will have made specific and documented efforts to identify chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

This objective has not been fully realized.

GOAL #4

GOAL #5

*1. DMH will offer periodic consultation services to Department of Health divisions (e.g., family health services, community health services, alcohol and drug abuse) which request such services.

No requests for consultation have been received. However, DMH staff have met with the Alcohol and Drug Abuse Division, the Office of Medical Care Regulation and Development, the State Health Planning and Development Agency and the Division of Vital Statistics.

*2. By January 1, 1977, the DMH will offer periodic consultation services to the Department of Social Services, the Judicial Department and the Department of Education.

DMH staff have met with DSS and DE staff many times during the first two quarters as indicated elsewhere in this report and in the previous report. There have been no formal contacts with the Judicial Department.

3. By January 1, 1977, all centers/clinics will have been requested to have at least one information sharing/mutual consultation session with public health nurses and other appropriate public health personnel concerning areas of shared responsibility and coordination of health services.

No report is available on the number of agencies which accomplished this objective.

4. By January 1, 1977, all centers/clinics will have been requested to have at least one information sharing/mutual consultation session with the regional alcohol and drug abuse coordinator.

This has been accomplished.

5. By January 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with county social services personnel to discuss mutual concerns and ways of improving services to mutual clients.

No report is available on the number of agencies which have accomplished this objective.

Status of
STATE PLAN OBJECTIVES
for
THIRD QUARTER
(January 1, 1977 through April 1, 1977)

*indicates written reports or other written materials are available.

GOAL #1

*a. By March 30, 1977, a uniform cost allocation procedure (to include cost definitions and detail methods of allocation of all fixed, variable and step variable costs) for the two state hospitals will be developed and implemented.

This objective has been accomplished.

*e. By March 1, 1977, a method for evaluating treatment outcome, comparable for the total system, will be decided upon by the DMH in consultation with the statewide Evaluation Advisory Committee.

This objective has not been accomplished. (Objective revised and new due date of December 1, 1977 established.)

*f. Quarterly meeting with representatives of the State Health Planning and Development Agency.

This objective has been accomplished.

*f. Quarterly meeting with the Department of Psychiatry, University of Colorado Medical Center.

This objective has been accomplished.

*f. Quarterly meeting with the Department of Social Services.

This objective has been accomplished.

*f. Periodic contacts will be established with the Department of Education and the Judicial Department to deal with areas of mutual concern, such as services to children and forensic issues.

This objective has been accomplished.

*f. Periodic contacts with such divisions of the Department of Health as family health services, alcohol and drug abuse and health facilities will be initiated.

This objective has been accomplished.

*g. By March 1, 1977, an annual inventory of existing facilities, as required by the State Plan, will be performed.

This objective has been accomplished.

*g. By March 1, 1977, an annual update of the personnal needs and resources of the mental health system will be accomplished.

This objective has been accomplished.

GOAL #2

*d. The DMH will designate for development one or more specialized mental health resource centers for educational materials which would be vailable to all mental health agencies. (Designation to be accomplished by March 30, 1977.)

This objective has been accomplished.

GOAL #3

*c. Quarterly meeting with Division of Services for the Aging.

This objective has been accomplished.

*f. The DMH will form a talent bank of minority mental health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos, Blacks, Native Americans and Asians. This group will develop a mechanism for the exchange of expert technical information in minority services, and make recommendations regarding programs to meet the special mental health needs of ethnic minority groups. (Extension of time to March 15, 1977.)

This objective has been accomplished.

f. By April 1, 1977, the results of the study of the ethnic and sex make-up of center/clinic staffs will be made available to the agencies concerned for use in updating affirmative action plans.

This objective has not been accomplished. Due date for the study changed to June 30, 1977.

*h. Meeting with appropriate State Department of Social Services and Regional DHEW staff to explore means of increasing the availability of funding for mental health services to the poor. The results of these meetings will be appropriately disseminated.

This objective has been accomplished.

j. Each catchment area agency will have made specific and documented efforts to identify chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

This objective has not been fully accomplished.

GOAL #5

*l. Periodic consultation services to Department of Health Divisions which request such services.

This objective has been accomplished.

·2. Periodic consultation services to the Department of Social Services, the Judicial Department and the Department of Education.

Consultative services available, but not requested. However, there were contacts with the three agencies during the third quarter.

*6. By March 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with school district staff and district and other court personnel.

This objective has been accomplished.

Exhibit No. 6

RICHARD D. LAMM
GOVERNOR

State of Colorado

DEPARTMENT OF SOCIAL SERVICES

1575 SHERMAN STREET
DENVER, COLORADO 80203

HENRY A. FOLEY, Ph.D.
Executive Director

August 11, 1977

Ms. Eillen Bradley
U.S. Commission on Civil Rights
Age Discrimination Study
1730 K St. NW Room 214
Washington, D.C. 20006

Dear Ms. Bradley:

At the Denver Hearing on Age Discrimination, you indicated that you were interested in information on active social services recipients by age groups. Enclosed is a report which shows a breakdown by age group and eligibility category for the month of July 1977. Some of the eligibility categories in this report are no longer valid and some are lumped into the "Other" category as indicated on the sheets.

We hope this report will be useful to you. If you have any questions regarding these data or need additional information, please let us know.

Very truly yours,

DEPARTMENT OF SOCIAL SERVICES

David L. Ashmore

DAVID L. ASHMORE, Director
Division of Title XX Services

DLA:dg
Attachment

DEPT. OF SOCIAL SERVICES

STATISTICAL SERVICE SUMMARY REPORT
ACTIVE RECIPIENTS AS OF 77-07

EXCPR1 PAGE 137

RUN DATE 08/10/77

STATE SUMMARY REPORT

	AGE SPANS										RACE CODES							
	UNDER-1	1-5	6-11	12-17	18-20	21-45	46-64	65-OVER	UNK.	AGE TOTAL	1	2	3	4	5	6	7	RACE TOTAL
CAT 01	0	0	0	0	0	7	26	2822	10.	2865	493	2184	93	6	3	7	79	2865
CAT 02	1	1	0	1	0	5	118	117	1	244	102	128	4	0	0	2	8	244
CAT 03	0	0	0	0	0	1	0	2	0	3	1	1	1	0	0	0	0	3
CAT 05	0	0	0	0	0	1195	1191	499	11	2896	550	2005	190	17	7	34	93	2896
CAT 06	0	2	9	3	0	20	25	7	0	66	23	40	1	0	0	0	2	66
CAT 07	0	1	1	0	0	0	1	0	0	3	0	3	0	0	0	0	0	3
CAT 08	0	0	0	0	0	2	2	1	0	5	0	5	0	0	0	0	0	5
CAT 52	0	0	0	0	0	1	1	14	0	16	0	13	1	0	0	0	2	16
CAT 58	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAT 62	0	0	0	0	0	2	0	0	0	2	0	2	0	0	0	0	0	2
CAT 68	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAT 91	0	8	11	9	4	15	0	0	0	47	18	13	15	0	0	0	1	47
CAT 92	0	1	6	1	0	4	0	0	0	12	2	2	8	0	0	0	0	12
S.TOTAL	1	13	27	14	4	1252	1364	3462	22	6159	1189	4396	313	23	10	43	185	6159
CAT 04	362	4181	4975	3773	1219	5165	545	31	85	20334	6907	9504	2893	203	13	85	729	20334
CAT 24	16	115	128	106	36	284	35	3	2	705	299	323	66	5	0	1	11	705
CAT 34	74	657	1578	1135	303	1900	181	6	45	5879	2019	2318	1065	54	9	15	399	5879
S.TOTAL	452	4953	6681	5014	1558	7329	759	40	132	26918	9225	12145	4024	262	22	101	1139	26918
CAT 50	4	11	13	36	17	1043	358	33	179	1694	253	1333	42	5	1	5	55	1694
OTHER	253	2786	2603	2718	676	4412	1045	1614	763	16870	3384	10882	1438	81	49	200	836	16870

CATEGORIES:
- 01 OLD AGE PENSION - CLASS A (SSI + STATE)
- 02 OLD AGE PENSION - CLASS B
- 03 OLD AGE PENSION - CLASS C
- 05 AID TO NEEDY DISABLED (SSI + STATE)
- 06 AID TO BLIND (SSI + STATE)
- 07 AID TO BLIND TREATMENT
- 08, 52, 58, 62, 68 } CATEGORIES ARE NO LONGER VALID
- 91 AFDC - DENVER INCOME MAINT. EXPERIMENT - DAY CARE
- 92 " " " " - DAY CARE ONLY.
- 04 AFDC
- 24 AFDC - UNEMPLOYED PARENT
- 34 WORK INCENTIVE PROGRAM (WIN SERVICES)
- 50 AFDC NON-RECIPIENT - PARENTS OR CARETAKER

OTHER: INCLUDES A WIDE RANGE OF CATEGORIES WHICH WERE RECENTLY ADDED

VARIOUS SUBTOTALS ARE USELESS

DEPT. OF SOCIAL SERVICES

STATISTICAL SERVICE SUMMARY REPORT
ACTIVE RECIPIENTS AS OF 77-07

EXCPR1 PAGE 138

RUN DATE 08/10/77

STATE SUMMARY REPORT

	AGE SPANS										RACE CODES							
	UNDER-1	1-5	6-11	12-17	18-20	21-45	46-64	65-OVER	UNK.	AGE TOTAL	1	2	3	4	5	6	7	RACE TOTAL
CAT 12	41	187	332	726	234	233	34	3	37	1827	308	1223	218	17	3	20	38	1827
CAT 13	8	150	170	417	71	40	3	3	4	866	319	400	106	14	2	11	14	866
CAT 14	123	1220	1681	2322	580	2139	393	21	486	8965	1576	5987	864	102	15	115	306	8965
S.TOTAL	172	1557	2183	3465	885	2412	430	27	527	11658	2203	7610	1188	133	20	146	358	11658
CAT 71	54	421	464	414	97	878	103	63	240	2734	366	1971	173	14	12	27	171	2734
CAT 72	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAT 73	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAT 74	0	13	37	17	6	52	7	0	2	134	32	92	7	0	0	0	3	134
CAT 75	0	1	4	0	0	7	1	0	0	13	9	4	0	0	0	0	0	13
CAT 76	0	5	11	7	0	14	0	0	0	37	1	36	0	0	0	0	0	37
CAT 78	0	0	2	1	0	2	1	0	0	6	0	6	0	0	0	0	0	6
S.TOTAL	54	440	518	439	103	953	112	63	242	2924	408	2109	180	14	12	27	174	2924
CAT 81	0	11	8	16	34	63	36	3	1	272	60	195	15	0	2	0	0	272
CAT 82	0	1	0	6	10	63	31	4	0	115	26	80	3	3	0	0	3	115
CAT 83	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CAT 84	0	151	307	114	20	327	19	1	15	960	118	781	20	0	8	6	27	960
CAT 85	0	9	9	6	7	27	6	0	0	66	24	37	2	0	0	0	3	66
CAT 86	0	0	2	4	4	2	0	0	0	12	0	12	0	0	0	0	0	12
S.TOTAL	0	172	326	148	85	582	88	8	16	1425	228	1105	40	3	10	6	33	1425
G.TOTAL	936	9932	12351	11834	3328	7983	4156	5247	1881	67648	16890	39580	7225	521	124	528	2780	67648

CATEGORIES

12 CHILD WELFARE - FOSTER CARE
13 AFDC FOSTER CARE
14 CHILD WELFARE - SERVICES ONLY (NOT FOSTER CARE)
71 WITHOUT REGARD TO INCOME ELIGIBILITY
72, 73, 74, 75, 76, 78 } CATEGORIES ARE NO LONGER VALID

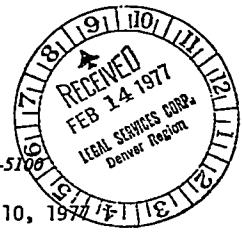
81 SSI ONLY - NO STATE SUPPLEMENT - AID TO NEEDY DISABLED
82 SSI ONLY - NO STATE SUPPLEMENT - AID TO BLIND
83, 84, 85, 86 } CATEGORIES ARE NO LONGER VALID

VARIOUS SUBTOTALS ARE USELESS

GRAND TOTAL IS PROBABLY THE MOST USEFUL SET OF FIGURES HERE.—
IT SHOWS NUMBER OF ACTIVE RECIPIENTS FOR EACH AGE GROUP.

Exhibit No. 7

LEGAL SERVICES CORPORATION
733 Fifteenth Street, N.W., Washington, D. C. 20005 (202) 376-5100



February 10, 1977

Dear Program Director:

On January 18, 1977, the Administration on Aging and the Legal Services Corporation signed a Statement of Understanding designed to promote cooperative working relationships here in Washington and throughout the country to increase access to legal services for the elderly. A copy of the Statement is enclosed.

With limited resources, legal services programs are able to provide only limited access for all of the poor, including the elderly. As more funds become available, however, it is essential that all of us be sensitive to the special problems associated with delivering services to the elderly. We know that older persons with legal problems do not always find their way to some legal services offices and many of them may not even recognize that they have legal problems for which they can obtain help.

Many legal services programs already are acting affirmatively to increase services to the elderly, through special outreach activities, designation of staff to work specifically with older persons, and assignment of specialists in areas of the law that have particular impact for the elderly, like SSI and medicaid/medicare. Where programs are not reaching the elderly poor and where these special efforts are not already under way, aggressive steps to do so should be taken. The Statement of Understanding emphasizes certain activities that can occur now - without substantial additional resources - including outreach and community education in senior citizens centers, nutrition sites, elderly housing projects, nursing homes and other places where elderly poor live and congregate.

If you have not already done so, we urge you to establish contact with your State and Area Aging Agencies and begin to explore means for developing working relationships that will result in more services to the elderly.

The Corporation has made a commitment under Objective Four to inventory legal services programs to determine any specialized activities for older persons they have undertaken already. You will be receiving a short questionnaire from us in the near future. Please complete and return it as soon as you can.

We welcome your suggestions about how the legal services community can best respond to the legal needs of the elderly poor.

Cordially,

Tom Ehrlich

Thomas Ehrlich

Enclosure

STATEMENT OF UNDERSTANDING

between

THE ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

and

THE LEGAL SERVICES CORPORATION

The need for legal services among persons who are elderly is becoming increasingly apparent. While older persons have the same legal problems as any other age group -- housing and consumer matters, for example -- they also have unique problems associated with their age, such as discrimination in employment, pensions, nursing homes and home health care, and an increasing reliance on public benefits. In addition, the relative lack of mobility of many older persons often causes difficulty in gaining access to legal services, even when they are available.

Congress has assigned responsibility for providing older persons access to legal assistance to both the Legal Services Corporation and the Administration on Aging. The Legal Services Corporation Act of 1974 authorizes the Corporation to provide financial support for legal assistance in noncriminal proceedings or matters to persons financially unable to afford such assistance. This group includes a substantial number of elderly people. The 1975 amendments to the Older Americans Act designated legal services as one of four priority services to be provided older persons through funds available to state and area aging agencies under Title III of that Act.

Because local legal services programs, in their efforts to deliver services to the elderly, confront particular problems of outreach, education, and transportation, and because the aging network is particularly suited to alleviating such problems, cooperation at the local level can lead to expanded services to the elderly. In many communities, where lack of funding limits local legal services programs to the general practice of law, the availability of resources under the Older Americans Act can make possible specialized services for the elderly. The participation of local legal services program personnel in the activities of the aging network, including education of older persons about their legal problems and training and technical assistance to network personnel working with older persons, can increase access to legal services for the elderly.

The purpose of this agreement is to promote such cooperative working relationships between the Administration on Aging and the Legal Services Corporation, and more importantly to encourage those relationships between LSC funded legal services programs and AoA funded projects and agencies at the state and local level, to maximize the capacity of both to provide access to legal services for the elderly, and to use their combined influence to encourage greater participation in such efforts by the private bar and by law schools. To realize that goal, the Administration on Aging and the Legal Services Corporation are committed to the following objectives:

1. To expand the awareness by legal personnel of the legal concerns and problems facing older persons;
2. To expand the understanding by older persons of their legal rights;
3. To increase the number of legal personnel trained to serve and working on behalf of the elderly of the nation; and

4. To improve the access of older persons to existing legal services and to increase the number of communities in which such services are available.

OBJECTIVE ONE: To expand the awareness by legal personnel of the legal concerns and problems facing older persons today.

In order to promote the achievement of this objective, the Administration on Aging will: (1) prepare a report on the social and legal problems facing older persons for distribution to law schools, legal organizations, legal services programs and legal journals; (2) encourage the inclusion of the legal concerns for older persons issue in national, regional and State legal conferences; (3) sponsor the drafting of suggested curricula materials relating to older persons for use in legal training programs; (4) encourage State and Area Agencies on Aging to be in contact with state and local bar associations and with legal services programs to discuss the legal problems of older persons and to explore ways in which the bar associations, legal services programs, and the National Network on Aging can cooperate to expand legal services to the elderly; (5) make available to law schools, legal organizations and legal services programs materials developed by legal services model project grantees; (6) sponsor the conduct of national and regional workshops on legal-social issues and the elderly; and (7) other activities which are appropriate to the achievement of this objective.

The Legal Services Corporation will: (1) make available the National Clearinghouse for Legal Services for the dissemination of materials prepared by the Administration on Aging and its grantees; (2) provide technical assistance to the Administration on Aging in the preparation of materials and in the conduct of workshops and conferences on the legal needs of the elderly; (3) encourage participation in such workshops and conferences by legal services program personnel; (4) directly or through the programs it funds, develop materials on substantive areas of the law affecting the elderly poor, and make such materials available to any program providing legal services to the elderly poor; (5) encourage local legal services programs to take steps to include among client members of their boards of directors older persons or representatives of the network on aging; and (6) other activities appropriate to the achievement of this objective.

OBJECTIVE TWO: To expand the understanding by older persons of their legal rights.

In order to promote the achievement of this objective, the Administration on Aging will: (1) develop, and encourage to be developed at the State and local level, a public education program designed to expand the awareness by older persons of their legal rights; (2) encourage national organizations on aging to disseminate information concerning the legal rights of older persons; (3) encourage State and Area Agencies on Aging to finance education programs on the legal rights of older persons with the resources

available under Title III and Title VII of the Older Americans Act; and (4) other activities which are appropriate to the achievement of this objective.

The Legal Services Corporation will: (1) encourage legal services programs to publicize the availability of legal services, through posters, pamphlets, newsletters, and other means, in senior citizens centers, nutrition sites, and areas where the elderly live; (2) encourage legal services programs to make regular visits to nutrition sites, senior citizens centers, elderly housing projects, and other places where older persons congregate, to explain their legal rights and remedies; (3) work with the Administration on Aging in the development of community education materials directly related to the legal problems of the elderly; (4) to the extent that resources are available, encourage legal services programs to provide information and technical assistance, where appropriate, to local aging agencies and programs serving the elderly; (5) disseminate the Legal Services Corporation newsletter to state and area aging agencies; (6) make available the services of the National Clearinghouse for Legal Services to state and area aging agencies; and (7) other activities appropriate to the achievement of this objective.

OBJECTIVE THREE: To increase the number of legal personnel trained to serve and working on behalf of the elderly of the nation.

In order to promote the achievement of this objective, the Administration on Aging will: (1) develop suggested curricula materials on legal services

to the elderly for use in legal training programs; (2) obtain base line data on the number of legal and paralegal personnel trained and working on behalf of the elderly; (3) identify legal services as a priority for the use of Title IV-A training funds; (4) expand the number of community service advisers, paralegals, and attorneys trained to serve the elderly; (5) continue and improve technical assistance to programs which are training legal personnel on legal problems of the elderly; and (6) other activities which are appropriate to the achievement of this objective.

The Legal Services Corporation will: (1) provide training to legal services program attorneys and paralegals on substantive areas of the law that affect the elderly; (2) utilize materials prepared by the Administration on Aging model projects and training grantees, as appropriate, for training of legal services program personnel; (3) encourage participation by legal services program personnel in state and local training programs funded under the Older Americans Act; (4) explore with the Administration on Aging the possibility of joint training activities at a regional level; (5) work with the law school clinics funded by the Administration on Aging to assure that students trained in serving the elderly are aware of employment possibilities in legal services programs and encourage local legal services programs to recruit personnel with such clinical experience; and (6) other activities appropriate to the achievement of this objective.

OBJECTIVE FOUR: To improve the access of older persons to existing legal services and to increase the number of communities in which such services are available.

In order to promote the achievement of this objective, the Administration on Aging will: (1) develop model program materials on legal services to the elderly; (2) expand the availability of technical assistance on problems of older persons to legal services programs at the State and local levels; (3) encourage State and Area Agencies on Aging to utilize Older Americans Act resources to stimulate the expansion of legal services for the elderly, awarding funds to existing legal services programs whenever possible; (4) encourage State and Area Aging Agencies to utilize existing outreach and transportation capabilities and resources available under Title III and Title VII of the Older Americans Act to enable older persons with legal problems to utilize legal services programs; (5) make available Title IV-A funds to train, and encourage State and Area Agencies on Aging to train social service, outreach, I&R and nutrition project personnel to identify and refer older persons experiencing legal problems; (6) disseminate to State and Area Agencies on Aging, legal services programs, bar associations and law schools materials which identify sources of funds for developing legal services to the elderly; (7) issue policies and guidelines for operation of legal services to the aging to the National Network on Aging; (8) inventory State and Area Aging Agencies to determine the extent to which they are funding legal services activities and the nature

of those activities; and (9) other activities which are appropriate to the achievement of this objective.

The Legal Services Corporation will: (1) establish a Project Reporting System that will yield data for each legal services program funded by the Corporation on the number of elderly clients served and the nature of the services provided; (2) inventory legal services programs funded by the Corporation to determine the extent to which they are working with the aging network, and to identify any specialized activities for older persons within existing legal services programs; (3) if the Project Reporting System and the inventory suggest that a program is seriously underserving the elderly poor, investigate the cause and assure that affirmative steps are taken as necessary to correct the imbalance; (4) work with the legal services development specialist program of the Administration on Aging at both the national and the state level to expand legal services accessible to older persons; (5) as part of the delivery system study, provide funds to test alternative models for delivering legal services to the elderly poor, particularly in rural areas; (6) subject to available funding, increase the capacity of existing legal services programs to serve all eligible clients, including those who are elderly; (7) subject to available funding, create new legal services programs in areas where none now exist to serve eligible clients, including those who are elderly; (8) encourage the development of local agreements between legal services programs and area aging agencies; and (9) other activities appropriate to the achievement of this objective.

In implementing each of the objectives listed above, the Administration on Aging and the Legal Services Corporation will consider joint activities, wherever feasible, to avoid duplication of efforts and to maximize the effective use of the resources of each organization.

The Commissioner on Aging and the President of the Legal Services Corporation will designate each a staff person to ensure that this agreement is properly implemented. One year following the signing of this agreement, the Administration on Aging and the Legal Services Corporation will prepare a report summarizing the specific progress made and obstacles confronted in implementing this agreement. The report will be disseminated to the aging network, Administration on Aging grantees, recipients of Legal Services Corporation funds, and other interested individuals and organizations, including appropriate Members of Congress and Congressional Committees.

Signed in Washington, D.C., on January 18, 1977

Arthur S. Flemming
Commissioner
Administration on Aging
U. S. Department of Health,
Education and Welfare

Thomas Ehrlich
President
Legal Services Corporation
Washington, D.C.

LEGAL PROBLEMS BY TYPE ACCEPTED

	DURANGO	GREELEY	ALAMOSA	LA JUNTA	GRAND JUNCTION	TRINIDAD	MONTROSE	TOTAL
TOTAL CONSUMER AND EMPLOYMENT PROBLEMS	21	11	10	12	18	11	7	90
SALES CONTRACTS	6	1	4	4	4	3	1	23
GARNISHMENT & ATTACHMENT	1	1	0	0	1	0	0	3
WAGE CLAIMS	2	0	2	2	1	0	0	7
BANKRUPTCY	2	0	0	1	3	1	0	7
OTHER	10	9	4	5	9	7	6	50
TOTAL ADMINISTRATIVE PROBLEMS	26	23	36	32	17	26	18	178
STATE & LOCAL WELFARE	8	10	12	5	10	11	11	67
WORKMEN'S COMPENSATION	2	0	0	0	0	1	1	4
SOCIAL SECURITY (OASB)	5	3	4	4	2	6	3	27
VETERAN'S ADMINISTRATION	2	0	0	0	0	0	0	2
UNEMPLOYMENT INSURANCE	3	0	4	2	2	1	1	13
OTHER	6	10	16	21	3	7	2	65
TOTAL HOUSING PROBLEMS	11	15	2	8	6	5	3	50
PRIVATE LANDLORD & TENANT	11	14	0	6	5	2	1	39
HOUSING CODE VIOLATIONS	0	0	0	0	0	0	0	0
PUBLIC HOUSING	0	0	0	0	0	0	1	1
OTHER	0	1	2	2	1	3	1	10
TOTAL FAMILY PROBLEMS	22	35	40	19	59	24	17	216
DIVORCE AND ANNULMENT	7	15	21	10	35	9	10	107
SEPARATION	1	1	1	0	0	1	0	4
NONSUPPORT	0	3	5	0	3	1	3	15
CUSTODY & GUARDIANSHIP	5	5	3	0	9	6	2	30
PATERNITY	0	1	2	1	0	1	0	5
ADOPTION	3	1	1	1	5	1	0	12
OTHER	6	9	7	7	7	5	2	43
TOTAL MISC. PROBLEMS	18	35	40	16	20	17	11	157
TORTS	2	4	2	2	5	11	4	30
JUVENILE	1	10	2	2	3	2	0	20
SCHOOL CASES	0	0	6	0	0	1	0	7
MISDEMEANORS	0	0	0	0	1	0	0	1
OTHER CRIMINAL	0	0	0	0	0	0	0	0
COMMITMENT PROCEDURES	2	4	27	0	0	0	0	33
OTHER	13	17	3	12	11	3	7	66
TOTAL	98	119	128	87	120	83	56	691

LEGAL PROBLEMS BY TYPE

NOT ACCEPTED

	DURANGO	GREELEY	ALAMOSA	LA JUNTA	GRAND JUNCTION	TRINIDAD	MONTROSE	TOTAL
TOTAL CONSUMER AND EMPLOYMENT PROBLEMS	4	14	3	7	2	5	4	39
SALES CONTRACTS	1	1	2	1	0	1	0	6
GARNISHMENT & ATTACHMENT	0	0	0	0	0	0	0	0
WAGE CLAIMS	0	4	0	2	0	0	0	6
BANKRUPTCY	0	1	0	1	0	2	1	5
OTHER	3	8	1	3	2	2	3	22
TOTAL ADMINISTRATIVE PROBLEMS	6	7	2	6	2	1	0	24
STATE & LOCAL WELFARE	0	3	2	0	1	0	0	6
WORKMEN'S COMPENSATION	0	2	0	0	0	0	0	2
SOCIAL SECURITY (OASB)	0	0	0	1	1	0	0	2
VETERAN'S ADMINISTRATION	0	0	0	0	0	0	0	0
UNEMPLOYMENT INSURANCE	0	0	0	0	0	0	0	0
OTHER	6	2	0	5	0	1	0	14
TOTAL HOUSING PROBLEMS	0	13	0	4	0	3	0	21
PRIVATE LANDLORD & TENANT	0	6	1	3	0	3	0	13
HOUSING CODE VIOLATIONS	0	0	0	0	0	0	0	0
PUBLIC HOUSING	0	1	0	0	0	0	0	1
OTHER	0	6	0	1	0	0	0	7
TOTAL FAMILY PROBLEMS	1	27	4	17	5	6	5	65
DIVORCE AND ANNULMENT	0	16	1	9	4	4	2	36
SEPARATION	0	1	1	0	0	0	0	2
NONSUPPORT	1	0	1	0	0	0	2	4
CUSTODY & GUARDIANSHIP	0	1	0	4	1	0	0	6
PATERNITY	0	0	0	0	0	1	0	1
ADOPTION	0	0	0	0	0	0	0	0
OTHER	0	9	1	4	0	1	1	16
TOTAL MISC. PROBLEMS	1	20	8	24	2	3	4	62
TORTS	1	0	2	2	0	1	1	7
JUVENILE	0	3	0	1	0	0	0	4
SCHOOL CASES	0	0	0	0	1	0	0	1
MISDEMEANORS	0	0	1	3	1	1	1	7
OTHER CRIMINAL	0	4	0	2	0	0	0	6
COMMITMENT PROCEDURES	0	0	0	0	0	0	0	0
OTHER	0	13	5	16	0	1	2	37
TOTAL	12	81	18	58	11	18	13	211

C.R.L.S. (9-76)

PARTICIPANT CHARACTERISTICS	DURANGO	GREELEY	ALAMOSA	LA JUNTA	GRAND JUNCTION	TRINIDAD	MONTROSE	TOTAL
TOTAL PARTICIPANTS	97	110	128	87	120	82	56	680
AGE RANGE								
0 - 5	0	0	0	0	0	0	0	0
6 - 15	0	6	1	0	1	1	0	9
16 - 21	13	15	17	9	17	13	6	90
22 - 44	56	65	75	65	77	38	28	404
45 - 64	11	20	31	7	18	20	13	120
65 and over	17	4	4	2	7	10	9	53
Age Unknown	0	0	0	4	0	0	0	4
FAMILY INCOME								
No. Above Poverty Line	15	14	0	25	6	10	2	72
No. Below Poverty Line	82	96	128	62	114	72	54	608
$ 1 - 499	34	15	65	12	39	13	24	202
$ 500 - 1,499 below	12	28	26	19	29	29	9	152
$1,500 or more below	36	53	37	31	46	30	21	254
TOTAL HEADS OF HOUSEHOLD	75	68	89	54	87	55	44	472
SEX								
Male	45	50	53	41	46	25	22	282
Female	52	60	75	46	74	57	34	398
RACIAL/ETHNIC GROUPS								
Caucasion	70	54	20	26	100	17	39	326
Mexican-American	16	55	107	61	20	65	17	341
Puerto Rican	0	0	0	0	0	0	0	0
Other Caucasion	0	0	0	0	0	0	0	0
Negro	0	0	1	0	0	0	0	1
American Indian	10	0	0	0	0	0	0	10
Oriental	0	0	0	0	0	0	0	0
Other	1	1	0	0	0	0	0	2
No. Farmworker	0	27	21	22	0	0	2	72

MISCELLANEOUS	DURANGO	GREELEY	ALAMOSA	LA JUNTA	GRAND JUNCTION	TRINIDAD	MONTROSE	TOTAL
SOURCES OF PARTICIPANTS								
No. Legal Referral	20	6	5	14	13	2	5	65
No. Outreach (by CRLS)	0	0	2	3	4	0	1	10
No. Referred by Another Participant	16	5	13	4	7	11	9	65
No. Previously Served	15	39	64	27	27	31	23	226
No. Through Publicity	8	9	2	4	6	28	4	61
No. From Social Welfare Agencies	15	4	2	4	11	3	6	45
No. Other	23	47	40	31	52	7	8	208
PARTICIPANT CHARACTERISTICS (New Cases)								
No. Employed	29	35	23	77	37	27	20	248
No. First-time Attorney-participant Contacts	54	71	69	95	93	80	16	478
No. Groups Seeking Service	1	0	0	0	0	0	0	1
No. Groups Served	1	0	0	0	0	0	0	1
No. Individuals in Groups Served	9	0	0	0	0	0	0	9
SOURCE OF INCOME								
Employment	29	35	23	77	37	27	20	248
Social Security	18	9	15	13	9	18	13	95
Unemployment Compensation	3	1	1	2	0	1	0	8
Other	11	6	1	32	27	10	9	96
Public Assistance (Specify)								
AFDC	17	21	18	20	5	18	6	105
SSI	2	6	3	0	5	14	8	38
Other	2	6	10	3	17	19	16	73

ANALYSIS OF CLOSED CASES	DURANGO	GREELEY	ALAMOSA	LA JUNTA	GRAND JUNCTION	TRINIDAD	MONTROSE	TOTAL
NUMBER REFERRED	4	6	0	7	2	17	3	39
No. Lawyer Referrals	3	4	0	6	0	14	3	30
No. To Other Grantee Programs	0	0	0	0	0	0	0	0
No. To Social Agencies	1	0	0	1	0	0	0	2
No. To Other Referrals	0	2	0	0	2	3	0	7
CASES WITHDRAWN AND NO. RECEIVING ADVICE ONLY	40	21	121	82	29	39	39	371
No. Where Action Further Than Above But No Litig. Or Admin. Action	23	24	16	74	13	28	25	203
No. In Above Where Client Objective Obtained	19	22	13	51	11	23	23	162
TOTAL CASES LITIGATED	16	33	2	62	16	13	16	158
Total Civil Court Proceedings	9	20	2	49	12	9	9	110
(Family Cases)								
No. Plaintiffs	5	6	2	13	10	2	6	44
No. Other Plaintiffs	0	0	0	0	0	0	0	0
No. Defendants	4	14	0	36	2	7	3	66
RESULTS IN CIVIL COURT PROCEEDINGS								
No. Won	6	17	1	25	12	9	10	80
No. Lost	3	3	0	14	3	1	2	26
No. Settled	7	13	1	23	1	3	4	52
FINANCIAL IMPACT ON CLIENT								
Settlement	$	$	$	$	$	$	$	$
Judgment	$	$	$	$	$	$	$	$
Benefit Award	$	$	$	$	$	$	$	$
Other	$	$	$	$	$	$	$	$

Exhibit No. 8

COLORADO REVISED STATUES 1973

COLORADO SCHOOL LAWS

1976

COMMUNITY EDUCATION RELATED

22-1-102 ----the board of Education shall have power to admit adults .....if it sees fit to do so and to fix the terms of such admission.

22-32-118----During that period of the calendar year not embraced within the regular school term, a board of education may provide and conduct courses in subject matters normally included in the regular school program or in demand by the pupils of the district, may fix and collect a charge for attendance at such courses in an amount not to exceed the per capita cost of the operation thereof, and may give regular school credit for satisfactory completion by students of such courses, in the discretion of the board. Such courses or programs not conducted during the regular school term shall not for any purpose, other than school credit, be considered part of the regular school program.

----A board of education may establish and maintain continuation programs, part-time programs, evening programs, vocational programs, programs for aliens, and other opportunity programs and may pay for such programs out of the moneys of the school district or charge a fee or tuition. A board may also establish and maintain open-air schools, playgrounds, and museums and may pay for the same out of moneys of the school district.

----a board may establish and maintain community education programs in cooperation with any unit of local government, quasi-governmental agency, institution of higher education, or civic organization and may pay for such programs by a fee or tuition charged or out of moneys of the school district.

----a board of education of a school district may establish and maintain preschool programs in connection with the schools of its district for the instruction of young children not yet eligible for kindergarten and may prescribe the educational activities and rules and regulations governing such programs. Said preschool programs shall provide opportunities for voluntary parental participation. Said preschool programs shall be a part of the public school system, and the cost of establishing and maintaining them may be paid from tuitions or gifts, or from the general school fund, or from state or federal moneys available to school districts for qualifying preschool programs.

COLORADO REVISED STATUES (Cont'd)

22-32-120----A board of education may establish, maintain, equip and operated a food service facility---for persons participating in or attending a school-sponsored activity...

22-32-128----motor vehicles used for the transportation of pupils... shall be available to groups of five or more residents of the district who are sixty-five years of age or older for use within or without the district.

29-7-102-----Any school district may operate a system of public recreation and playgrounds, and television relay, translator facilities, and may exercise all other powers enumerated in Section 29-7-101. (29-7-101 describes and defines public recreation and playgrounds and discusses the rules relating to them.)

30-20-702----such county may establish a recreation district. This district shall be composed of the unincorporated area benefited by the establishment of the proposed recreational facility, the boundaries to be designated by the board of county commissioners.

30-20-701----acting on behalf of such district, the board of commissioners may: (a) levy a tax....not to exceed one mill,...

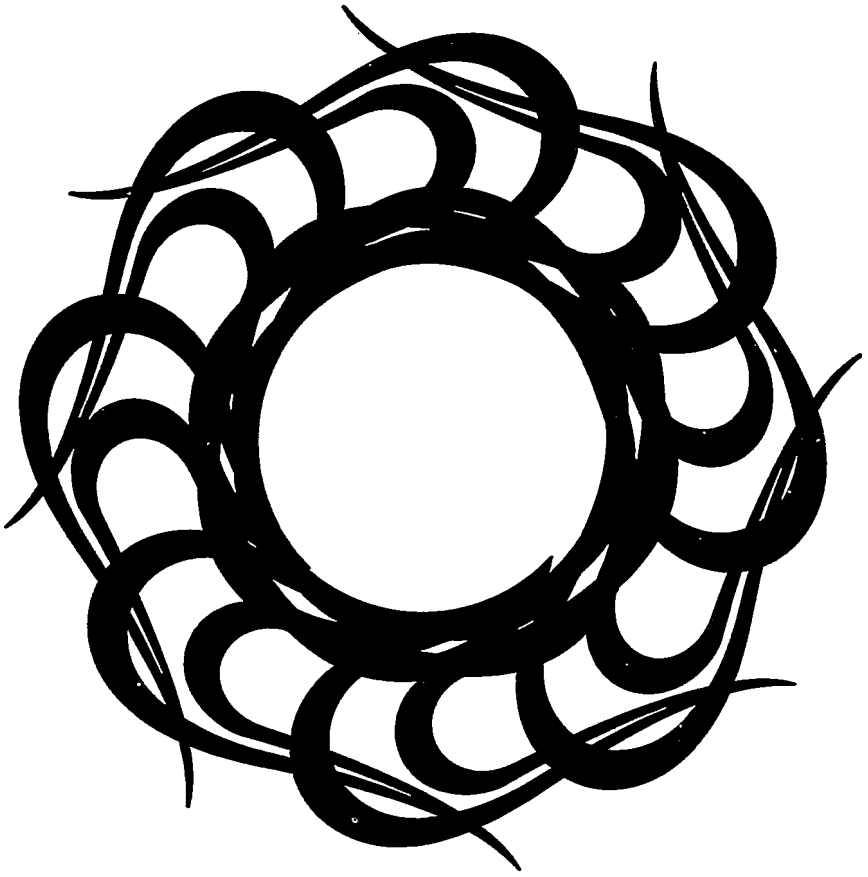
32-2-115-----For the purpose of providing revenue for such districts the board has the power to levy and collect ad valorem taxes on and against all taxable property within the district; but in no event shall such levy exceed four mills in any one year.

The "Adult Education Annual Performance Report" attached to this exhibit is on file at the U.S. Commission on Civil RIghts.

Exhibit No. 9

The Summer Schedule 1977 for the University of Colorado at Denver Division of Continuing Education is on file at the U.S. Commission on Civil Rights.

1977-78
University of Colorado at Denver



CONTENTS

ACADEMIC CALENDAR[1]

Summer 1977	
April 1	Financial aid application deadline. (Late applications may be considered for any funds remaining after all on-time applications have been processed.)
April 1	International student application deadline.
May 1	New student application deadline. (The deadline may be extended if space is available.)
June 1, 2	Registration.
June 6	First day of classes.
June 6, 7	Late registration.
June 10	Last day to add or drop a course without approval.
July 4	Holiday (no classes).
August 12	End of semester.
Fall 1977	
April 1	Financial aid application deadline. (Late applications may be considered for any funds remaining after all on-time applications have been processed.)
June 15	International student application deadline.
July 15	New student application deadline. (The deadline may be extended if space is available.)
August 30, 31, September 1	Registration.
September 6	First day of classes.
September 6-9	Late registration.
September 19	Last day to add or drop a course without approval.
October 14	Financial aid application deadline for spring semester, 1978. (Late applications may be considered for any funds remaining after all on-time applications have been processed.)
November 24, 25	Thanksgiving holidays (no classes).
December 6, 7, 8	Early registration for currently enrolled students for spring semester, 1978.
December 23	End of semester.
Spring 1978	
January 24-26	Registration.
January 30	First day of classes.
January 30-February 3	Late registration.
February 13	Last day to add or drop a course without approval.
March 19-26	Spring vacation (no classes).
May 26	End of semester.
Summer 1978	
June 6-7	Registration.
June 12	First day of classes.
June 12-16	Late registration.
July 4	Independence Day holiday.
August 18	End of semester.

[1]The University reserves the right to alter the Academic Calendar at any time.

DEGREE PROGRAMS AT A GLANCE[1]

	Baccalaureate Programs	Master's Programs
HUMANITIES	communication and theatre, distributed studies, English, fine arts, French, German, philosophy, Spanish, writing	communication and theatre, communication disorders and speech science, English, humanities
BUSINESS	(areas of emphasis) accounting, finance, international business, marketing, minerals land management, organization management, personnel management, production and operations, public agency administration, real estate, small business management, transportation and traffic management	acccounting, business administration (M.B.A.), finance, management and organization, marketing
EDUCATION	elementary education, secondary education, rehabilitation services	early childhood education, educational psychology, elementary education, guidance and counseling, library media, reading, secondary education, social foundations
ENGINEERING	applied mathematics, civil and environmental engineering, electrical engineering, electrical engineering and computer science	applied mathematics, civil engineering, electrical engineering
ENVIRONMENTAL DESIGN	offered only at Boulder –	architecture, architecture in urban design, interior design (anticipated for fall 1977), landscape architecture, urban and regional planning
MUSIC	science in music and media	
NATURAL AND PHYSICAL SCIENCES	biology, chemistry, geography, geology, mathematics, physics, psychology	basic science — biology, chemistry, or environmental science, geography, mathematics, psychology
PUBLIC AFFAIRS		public administration, urban affairs (also, doctorate in public administration)
SOCIAL SCIENCES	anthropology, economics, history, political science, sociology, urban studies	anthropology, economics, history, political science, sociology

[1]Courses in many other undergraduate and graduate areas are offered at UCD, but degrees must be completed at the University of Colorado at Boulder. UCD also offers preprofessional programs in law, journalism, and the health sciences (child health associate, dental hygiene, dentistry, medical technology, medicine, nursing, optometry, osteopathy, pharmacy, and physical therapy).

UNDERGRADUATE AND SPECIAL STUDENT ADMISSION INFORMATION[1]

Type of Applicant	Criteria for Admission[2]	Required Credentials	When to Apply	Notes
FRESHMAN (Students seeking a bachelor's degree who have never attended a collegiate institution)	In general: Rank in upper 50% of high school graduating class. Have 15 units of acceptable high school work. Minimum test scores: Resident Nonresident ACT comp: 23 24 or SAT comb: 1000 1050	Complete application $10 application fee Official high school transcript showing rank-in-class, date of graduation, 7th semester grades, 6th semester courses Official ACT or SAT score report.	Not later than: July 1 for fall Dec. 1 for spring May 1 for summer Seniors who meet or exceed all admission criteria may apply as early as Oct. 1 for following fall.	For specific requirements refer to the college sections of this bulletin.
TRANSFER[1] (Students seeking a bachelor's degree who have attended a collegiate institution other than CU)	Must be in good standing and eligible to return to all institutions previously attended. Residents must have a minimum 2.0 (C) GPA on all work attempted. Nonresidents must have a minimum 2.5 (C+) GPA on all work attempted.	Complete application $10 application fee One official transcript from each college attended	Not later than: July 1 for fall Dec. 1 for spring May 1 for summer	Transfers to the School of Education consult page 51 for additional requirements. Transfers with less than 12 semester hours of University acceptable transfer credit must also submit all required freshman credentials.
SPECIAL (Students who are not seeking a degree at this institution)	Must be at least 21 years old (except in summer). Must be high school graduate. Must be in good standing and eligible to return to all institutions previously attended.	Complete application	Not later than: July 1 for fall; Dec. 1 for spring; May 1 for summer Application will also be accepted at registration if space allows.	Graduate special students, see page 80 for additional information.
RETURNING CU STUDENT (Returning special students, returning degree students who have not attended another institution since CU)	Must be in good standing	Former student application	Same as for special students	Students under academic suspension in certain schools or colleges at the University of Colorado may enroll during the summer term as a means of improving their grade-point averages.
RETURNING CU STUDENT (Returning degree students who have attempted 12 or more hours at another institution since attending CU)	Same as for transfers	Same as for transfers plus Courses in progress form CU transcript	Same as for transfers	
CHANGE OF STATUS: SPECIAL TO DEGREE (Former CU special students who wish to enter a degree program)	Same as for transfers	Same as for transfers	Same as for transfers	
CHANGE OF STATUS: DEGREE TO SPECIAL (Former CU degree students who have graduated and wish to take additional work)	Must have completed degree. Must be in good standing and eligible to return to all institutions attended.	Special student application	Same as for special students	Only students who have completed and received degree are eligible to change to special status.
INTERCAMPUS TRANSFER (Students who have been enrolled on one CU campus and wish to take courses on another)	Must be in good standing	Former student application	Transfer to Denver: same as for specials Transfer from Denver: refer to appropriate bulletin.	Transfers from Denver to another campus of CU should refer to appropriate bulletin for additional requirements.
INTRAUNIVERSITY TRANSFER (Students who wish to change from one CU college to another, e.g., from the College of Liberal Arts and Sciences to the College of Business)	Same as for transfers	Intra-university transfer application CU Transcript	Same as for transfers	

[1]Applications will be accepted only as long as openings remain.
[2]Requirements for individual schools or colleges may vary.

General Information

THE UNIVERSITY OF COLORADO AT DENVER: AN URBAN UNIVERSITY CAMPUS

The University of Colorado at Denver (UCD) is an urban nonresidential campus located in downtown Denver. The campus is easily accessible to commuters from an eight-county area and is close to major businesses and government offices in downtown Denver, as well as to civic and cultural centers. UCD is one of the largest state-supported institutions of higher education in Colorado in terms of enrollment, with an average of 8,000 students enrolled during a semester.

The UCD Administration Building is located at 1100 Fourteenth Street. UCD shares library, laboratory, classroom, and recreational facilities with two other metropolitan institutions on a single campus, the Auraria Higher Education Center.

Academic Programs

UCD is committed to meeting the needs of the metropolitan Denver community. Academic, public service, and research activities are geared to the needs of the urban population and environment, encompassing both traditional and nontraditional fields of study. Students enrolled at UCD can earn undergraduate degrees in 40 fields and graduate degrees in 50 fields. The colleges and schools at UCD are:

College of Liberal Arts and Sciences
College of Business and Administration and Graduate School of Business Administration
School of Education
College of Engineering and Applied Science
College of Environmental Design
College of Music
Graduate School
Graduate School of Public Affairs

The undergraduate colleges admit freshmen and offer programs leading to the baccalaureate degree in the arts, sciences, humanities, business, engineering, and music. The College of Liberal Arts and Sciences also provides preprofessional training in the fields of education, law, journalism, and the health sciences. The School of Education offers programs leading to the baccalaureate degree in education and teacher certification to students with two years of college work. The Graduate School offers master's programs in the arts, sciences, humanities, engineering, business, education, and music to students with baccalaureate degrees. The College of Environmental Design, the Graduate School of Business Administration, and the Graduate School of Public Affairs provide programs leading to the master's degree in their specialized areas. The Graduate School of Public Affairs also offers a doctorate in public administration.

Students

Highly motivated people from all walks of life make up UCD's student body. The diversity of backgrounds, interests, occupations, and ages stimulates a unique learning experience for the men and women enrolled at UCD. Students range in age from 16 to 70. Approximately one-third of the students hold full-time jobs and 60 percent are enrolled at the upper division or graduate level. In order to give students maximum flexibility in planning both educational and employment goals, more than half of the courses are offered during the evening hours. Students may begin studies in most areas at the beginning of the 15-week fall or spring semester, or the 10-week summer term.

Faculty and Accreditation

More than 230 highly qualified faculty members teach full time at UCD; 70 percent have doctoral degrees. The faculty is alert to the challenges of the urban environment and responsive to the needs of the commuter student. UCD is accredited by or holds membership in the following organizations:

ACCREDITATION

North Central Association of Colleges and Secondary Schools
National Council for the Accreditation of Teacher Education
National Architecture Accrediting Board
National Association of Schools of Music

MEMBERSHIP

Association of Urban Universities
American Assembly of Collegiate Schools of Business
American Association of Colleges of Teacher Education
Association of Collegiate Schools of Architecture and Collegiate Schools of Planning

National Association of Schools of Public Affairs and Administration

The Engineers' Council for Professional Development has accredited the programs in civil engineering and in electrical engineering in the College of Engineering and Applied Science.

University of Colorado System

UCD is one of four campuses of the University of Colorado. The University was founded in Boulder in 1876, and the University of Colorado at Boulder now serves over 20,000 students enrolled in undergraduate, graduate, and professional programs. The Medical Center in Denver provides education and training to medical, dental, nursing, and allied health personnel. The University of Colorado at Colorado Springs serves over 3,000 students in the Pikes Peak region, offering undergraduate, graduate, and professional programs. UCD's special role within the University system is to provide urban-oriented educational programs for students in the Denver Metropolitan area.

Qualified students may begin programs of study in some undergraduate, preprofessional, and graduate areas that they must complete at other University campuses. Under certain circumstances, UCD students may enroll for courses offered by the other campuses. Students also have access to the library resources of all campuses and cultural events sponsored within the University system.

Auraria Higher Education Center

The Auraria Higher Education Center is a cooperative effort by the University of Colorado at Denver, Metropolitan State College, and the Auraria Branch of the Community College of Denver to meet the higher education needs of metropolitan Denver. The three institutions share library, classroom, and related facilities on the Auraria campus, a 168-acre site in downtown Denver.

The Auraria Higher Education Center combines the educational strengths of the three participating institutions. Each institution offers distinctive educational opportunities to students seeking a higher education. The Community College of Denver provides vocational programs and two-year associate degree programs; Metropolitan State College has four-year programs leading to the baccalaureate degree. The University of Colorado at Denver is the university component, offering undergraduate, preprofessional, professional, and graduate programs. Interinstitutional enrollment agreements among the three institutions provide students with a broader range of courses than could be offered by a single institution.

The Auraria campus includes three administration buildings, five classroom buildings, the Learning Resources Center, the student center, child care and development centers, the physical education building, and two service buildings. The Learning Resources Center houses over 300,000 books and periodicals, related instructional materials, and a media production center with laboratories for television, photography, and graphic design studies. The new facilities were completed in January 1977. The new buildings share the campus with reminders of Denver's past — 19th-century houses, churches, and the famous Tivoli brewery built in 1882. The brewery will be converted into small shops, restaurants, and a theatre.

Equal Opportunity

The University of Colorado at Denver follows a policy of equal opportunity in education and in employment.

In pursuance of this policy, no UCD department, unit, discipline, or employee shall discriminate against an individual or group on the basis of race, sex, creed, color, age, national origin, or individual handicap. This policy applies to all areas of the University affecting present and prospective students or employees.

The institution's educational programs, activities, and services offered to students and/or employees are administered on a nondiscriminatory basis subject to the provisions of the Titles VI and VII of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972.

A UCD Equal Opportunity/Affirmative Action Program has been established to implement this policy. For information about these provisions or equity, discrimination, or fairness, consult either of the following persons who will advise individuals of existing complaint procedures within and outside the University: Affirmative Action Director Nereyda Bottoms, Room 806, 1100 Fourteenth Street (telephone: 629-2621; Title IX Coordinator Alice Owen, 1100 Fourteenth Street (telephone: 620-2726).

I. ADMISSION POLICIES AND PROCEDURES

General Policies

UCD seeks to identify applicants who are likely to complete an academic program successfully. Admission decisions are based on many factors, the most important being:

1. Level of previous academic performance.
2. Evidence of scholarly ability and accomplishment, as indicated by scores on national aptitude tests.
3. Ability to work in the academic environment of an urban, nonresidential campus.
4. Maturity, motivation, and potential for academic growth.

UCD reserves the right to deny admission to new applicants or readmission to former students whose total credentials indicate an inability to assume those obligations of performance and behavior deemed essential by the University in order to carry out its lawful missions, processes, and functions as an educational institution.

Admission of Undergraduate Degree Students

All questions and correspondence regarding undergraduate admission to UCD should be directed to:

Office of Admissions and Records
University of Colorado at Denver
1100 Fourteenth Street
Denver, Colorado 80202
(303) 629-2660

APPLICATION DEADLINES

Undergraduate Students	*Fall 1977*	*Spring 1978*	*Summer 1978*
New Students	June 15	October 1	
Transfer Students	June 15	October 1	
Former University of Colorado Students	July 15	November 1	
Intrauniversity Transfer Students	90 days prior to the beginning of the term		

The University reserves the right to change application deadlines in accordance with enrollment demands, and applicants should apply as early as possible. Updated information is available from the Office of Admissions and Records, (303) 629-2660. All documents required for admission must be received by the Office of Admissions and Records by the deadline for an applicant to be considered for the admission for the term desired. Applicants who are unable to meet the deadline may elect to have admission consideration made for a later term. Transfer students are reminded that sufficient time should be allowed to have transcripts sent from institutions attended previously, and foreign students are advised that it usually takes 120 days for credentials to reach the Office of Admissions and Records from international locations.

ADMISSION REQUIREMENTS FOR FRESHMEN

New freshmen may apply for admission to the Colleges of Business and Administration, Engineering and Applied Science, Liberal Arts and Sciences, and Music.

1. General Requirements. The applicant must be a high school graduate or have been awarded a High School Equivalency Certificate by completing the General Education Development (GED) Test. Applicants with a High School Equivalency Certificate must have scored at or above the 60th percentile on each section of the GED test to be considered for admission. Applicants who have completed the Spanish Language General Educational Development Test must also submit scores from Test VI, "English as a Second Language."

Applicants should have completed 15 units of acceptable secondary school (grades 9-12) credit. A unit of credit is one year of high school course work. While the College of Liberal Arts and Sciences does not specify particular units, the other undergraduate colleges have the following requirements:

College of Business and Administration

English	3
Mathematics (college preparatory)	2
Natural sciences (laboratory type)	2
Social sciences (including history)	2
Electives	6
(Such as foreign languages and additional academic courses. May include up to 2 units in business areas.)	
Total	15

College of Engineering and Applied Science[1]

English	3
Algebra	2
Geometry	1
(Trigonometry and higher mathematics recommended.)	
Natural sciences	2
(Physics and chemistry recommended.)	
Social studies and humanities	2
(Foreign languages and additional units of English, history, and literature are included in the humanities.)	
Electives	5
Total	15

College of Music

English	3
Theoretical music, Physical science, Social science, Foreign language, Mathematics	8
Additional high school academic units	4
Total	15

It is expected that all students will have had previous experience in an applied music area. Two years of piano training are recommended.

The College of Music requires an audition of all entering freshmen and undergraduate transfer students. In lieu of the personal audition, applicants may substitute tape recordings (about 10 minutes in length on 7½ ips monaural) or a statement of excellence by a qualified teacher. Interested students should write to the College of Music, UCD, for audition or interview applications.

2. Colorado Residents.[2] Colorado residents who meet the above requirements are classified in two ways for admission purposes.

a. Preferred consideration — applicants who rank in the upper half of their high school graduating class and have a composite score of 23 or higher on the American College Test (ACT) or a combined score of 1000 or higher on the Scholastic Aptitude Test (SAT). Engineering applicants are expected to have a strong mathematics and science background and somewhat higher scores on the mathematics portion of the ACT or SAT.
b. Considered on an individual basis — applicants who rank in the lower half of their high school graduating class, and/or have combined SAT scores below 1000 or a composite ACT score below 23, and/or do not have 15 units of acceptable high school credit.

3. Nonresidents[2]. Nonresidents must meet the general requirements given above and must rank in the upper 40 percent of their high school class and have an ACT composite score of 25 or above or a combined SAT score of 1050 or above to be considered for admission. Nonresidents are advised that UCD does not maintain housing facilities for students.

[1] See page 64 for the level of mathematical competence desirable for engineering students.
[2] See page 8 for a definition of "resident" and "nonresident."

How to Apply

1. Students should obtain an Application for Admission from their high school counselor or the Office of Admissions and Records at UCD, 1100 Fourteenth Street, Denver, Colorado 80202, (303) 629-2660.

2. The application must be completed in full and sent to the Office of Admissions and Records. A $10 nonrefundable application fee must accompany the application. An applicant who is granted admission but who is unable to enroll for the term applied for will have the $10 fee valid for 12 months, provided the applicant informs Admissions and Records that he or she intends to enroll for a later term.

3. Students must have their high school send a transcript of their high school grades, including class rank, to the Office of Admissions and Records.

4. The student must take either the American College Test (ACT) or the Scholastic Aptitude Test (SAT) and request that test scores be sent to UCD (ACT code 0533 or SAT code R-4875). High school students may obtain information from their counselors regarding when and where tests are given. The ACT is given at UCD once a month; students may register for the test by calling the Testing Center, Office for Student Affairs, (303) 629-2861. Applicants who took one of these tests earlier and did not designate UCD to receive scores must request that scores be sent to UCD. This is done by completing a Request for Additional Score Report available at test centers or from the offices listed below.

Registration Department
American College Testing Program (ACT)
P. O. Box 414
Iowa City, Iowa 52240

College Entrance Examination Board (SAT)
P. O. Box 592
Princeton, New Jersey 08540

College Entrance Examination Board (SAT)
P. O. Box 1025
Berkeley, California 94704

5. Students must have GED test scores sent to UCD if they have High School Equivalency Certificates.

Checklist of Application Materials

1. Completed application form.
2. $10 application fee.
3. High school transcript of grades including class rank.
4. SAT or ACT test scores.
5. GED scores (for applicants with a High School Equivalency Certificate) *and* copy of GED Certificate.

All credentials presented for admission become the property of the University of Colorado and must remain on file.

ADMISSION REQUIREMENTS FOR TRANSFER STUDENTS

Transfer students may apply for admission to the Colleges of Business and Administration, Engineering and Applied Science, Liberal Arts and Sciences, and Music. Students interested in the field of education should contact the School of Education office for information, 629-2717.

1. Colorado Residents.[1] Colorado residents who want to be considered for transfer admission to UCD must have at least a 2.0 cumulative grade-point average calculated on all work attempted and be eligible to return to all institutions previously attended. Applicants to the Colleges of Business and Administration or Engineering and Applied Science must have a higher grade-point average to be considered for admission. Music applicants must successfully complete a music audition. The student must have completed at least 12 semester credits (18 quarter credits) of work acceptable to the University. Students who have completed fewer than 12 semester credits must meet the admission requirements for freshmen. Students are grouped as follows for admission purposes:

a. Preferred consideration — applicants who meet the above academic standards and have completed more than 12 semester credits (18 quarter credits) from an institution of university rank, and applicants who have completed at least 45 semester credits (68 quarter credits) from an institution of non-university rank (i.e., community college, state college).
b. Considered on an individual basis — applicants who meet the academic standards listed above and who have completed fewer than 45 semester credits (68 quarter credits) from an institution of non-university rank (i.e., community college, state college) or those whose previous academic work does not meet the above standards. Primary factors considered are: (1) the college or school to which admission is desired; (2) quality of prior academic work; (3) age, maturity, and noncollegiate achievements; and (4) time elapsed since last attendance.

2. Nonresidents.[1] Nonresident applicants to the professional Colleges of Business and Administration and Engineering and Applied Sciences must have a transferable grade-point average of at least 2.6 to be considered for admission. A 2.0 grade-point average is sufficient for consideration for admission to the Colleges of Liberal Arts and Sciences or Music. Nonresidents are advised that UCD does not maintain student housing facilities.

How to Apply

1. The student should obtain a transfer application from the UCD Office of Admissions and Records, 1100

[1]See page 8 for a definition of "resident" and "nonresident."

Fourteenth Street, Denver, Colorado 80202, (303) 629-2660.

2. The application form must he completed and returned to the Office of Admissions and Records with the $10 nonrefundable application fee.

3. The student must have an official transcript sent to the Office of Admissions and Records from each collegiate institution attended. If a student is currently enrolled, a transcript listing all courses except those taken in the final term should be sent. Another transcript must be submitted after completion of the final term.

4. Applicants to the College of Liberal Arts and Sciences should be aware that they may be able to receive credit for foreign language taken during the high school years providing they furnish an official high school transcript. Further information may be obtained from the College of Liberal Arts and Sciences.

All credentials presented for admission become the property of the University of Colorado and must remain on file.

Transfer of College-Level Credit

The Office of Admissions and Records and the appropriate dean's office will determine which courses taken at another institution can be applied to a degree program at UCD after all transcripts have been received and the applicant has been admitted. In general, transfer credit will be accepted insofar as it meets the degree, grade, and residence requirements at UCD.

College-level credit may be transferred to the University if it was earned at a college or university of recognized standing, by advanced placement examinations, or in military service or schooling as recommended by the Commission on Accreditation of Service Experiences of the American Council on Education; if a grade of *C* or higher was attained; and if the credit is for courses appropriate to the degree sought at this institution.

The University will accept up to 72 semester credits (108 quarter credits) of junior college work toward the baccalaureate degree requirements. No credit is allowed for vocational/technical, remedial, or religious/doctrinal work. A maximum of 60 semester credits of extension and correspondence work (not to include more than 30 semester credits of correspondence) may be allowed if the above conditions are met.

For more detailed information by school and college regarding the transfer of college-level credit, see Academic Policies and Regulations.

Readmission Requirements for Former Students

1. Students Who Have Not Attended Another Institution. Former students of the University of Colorado who have not attended another collegiate institution since their last enrollment at the University must submit a Former Student Application, available from the Office of Admissions and Records, hy the deadline for the term desired. No application fee and no supplementary credentials are required.

2. Students Who Have Attended Another Institution. Former students of the University of Colorado who have attended another collegiate institution since their last enrollment at the University must submit a Former Student Application and official transcripts from any institutions attended in the interim. Applicants who have completed 12 semester hours or 18 quarter hours at another institution since last attending the University also must submit a $10 nonrefundable evaluation fee.

Requirements for Intrauniversity Transfer

UCD students or former University of Colorado students may change colleges or schools within the University of Colorado provided they are acceptable to the college or school to which they wish to transfer. Transfer forms may be obtained from the Office of Admissions and Records. Students should observe application deadlines indicated in the current *Schedule of Courses.* Decisions on intrauniversity transfers are made by the college or school to which the student wishes to transfer.

High School Concurrent Enrollment

High school juniors and seniors with proved academic abilities may be admitted to UCD for courses which supplement their high school programs. Credit for courses taken may subsequently be applied toward a University degree program. For more information and application instructions, contact the Office of Admissions and Records, (303) 629-2660.

Admission of Graduate Degree Students

All correspondence and questions regarding admission to the graduate programs at UCD should be directed to the following:

Programs in Business
Office of Graduate Studies
Graduate School of Business Administration
629-2605

Programs in Environmental Design
College of Environmental Design
629-2877

Programs in Public Affairs
Graduate School of Public Affairs
629-2825

All Other Programs
Graduate School
629-2663

The above offices are located at 1100 Fourteenth Street, Denver, Colorado 80202.

[1] See page 8 for a definition of "resident" and "nonresident."

GRADUATE PROGRAMS

As a principal part of its mission, UCD offers graduate- and professional-level programs for the convenience of Denver residents. During the 1976-77 academic year, approximately 35 percent of the student body was enrolled at the graduate level.

Graduate degree programs are offered through the Graduate School by its member schools and colleges, and outside the Graduate School by the Graduate School of Business Administration, the College of Environmental Design, and the Graduate School of Public Affairs. The particular admission and graduation requirements established by each of these academic units are detailed in the following sections.

Students holding baccalaureate degrees but who are not accepted to specific degree programs may enroll for graduate course work as *graduate special students.* Several types of students make use of the special student category. Among these are students who have attained whatever degree or credential status they feel is desirable, but who wish to take additional course work for professional or personal improvement; students who, for whatever reason (weak undergraduate background, change of discipline, or length of time since previous formal course work), feel the need to make up deficiencies before entering a degree program; and students who have not decided about entering a specific degree program. Such students should be aware that, generally, only limited course credits taken as a special student may be applied toward a degree program. Also, a 2.0 minimum grade-point average must be maintained to permit continuing registration in this category.

ADMISSION REQUIREMENTS AND APPLICATION DEADLINES

Admission requirements and application deadlines vary according to the individual graduate program. The Graduate School has general admission requirements which are supplemented by specific requirements of the major departments of graduate study (i.e., electrical engineering, education, English, etc.). Applicants in the fields of education, engineering, and the arts, sciences, and humanities should consult the general information section of the Graduate School portion of this bulletin as well as the following sections dealing with requirements and deadlines for specific programs. Applicants in the fields of business, public affairs, and environmental design should refer to the sections of this bulletin on the Graduate School of Business Administration, the Graduate School of Public Affairs, and the College of Environmental Design.

Admission of Nondegree Special Students

All correspondence and questions regarding admission as a special student should be directed to:

Office of Admissions and Records
1100 Fourteenth Street
Denver, Colorado 80202
(303) 629-2660

Persons desiring admission as special students for the purpose of teacher certification should contact the School of Education, 629-2717.

APPLICATION DEADLINES

Special Students	*Fall 1977*	*Spring 1978*	*Summer 1978*
Those who want to take undergraduate or graduate courses	July 15	December 1	May 1
Those who want to change from special to degree status	July 15	December 1	May 1
Those who want teacher certification	February 1	N.A.	February 1

REQUIREMENTS FOR ADMISSION

Persons who want to take University courses but do not plan to work toward a University of Colorado degree are admitted as special students. Courses taken as a special student are fully credited and can be used for transfer to other institutions or for professional improvement. Persons who do not have an undergraduate degree are encouraged to apply to an undergraduate degree program rather than apply as special students. UCD will admit adults (over 21 years of age) without an undergraduate degree as special students for one semester or summer term only; after that the student must apply to a regular degree program. Persons with a baccalaureate degree who seek teacher certification or renewal of certification may be admitted as special students if they meet the requirements of the School of Education. Special students must maintain a grade-point average of 2.0.

HOW TO APPLY

To apply for admission as a special student, obtain a Special Student Application Form from the Office of Admissions and Records. Return the completed application by the deadline for the term desired. There is no application fee, and no additional credentials are required. Applicants who seek teacher certification or renewal of teacher certification must apply separately to the School of Education and submit the required credentials.

Special students are advised that registration for courses is on a "space available" basis.

CHANGING STATUS FROM SPECIAL TO DEGREE STUDENT

Special students may apply for admission to an undergraduate degree program by completing the Special to Degree Application available from the Office of Admissions and Records. Academic credentials (i.e., transcripts and test scores) and a $10 nonrefundable application fee must be submitted with the application. Special students who are accepted as undergraduate degree students may transfer a maximum of 12 semester credits for courses taken as a special student to an undergraduate degree program, with approval by the dean. (Students enrolled as special students prior to the fall semester of 1970 are

subject to the policies in effect between January of 1969 and August of 1970.)

Special students may apply for admission to a graduate degree program by completing the application required by the particular program. The graduate dean, upon recommendation by the department, may accept up to 8 semester hours of credit toward the requirements for a master's degree for courses taken as a special student at the University or at another recognized graduate school, or some combination thereof. The department may recommend acceptance of additional credit for courses taken as a special student during the semester the student has applied for admission to the desired degree program.

Official Notification of Admission

Official notification of admission to UCD as an undergraduate, graduate, or special student is provided by the Office of Admissions and Records on a Statement of Admission Eligibility Form. Letters from the various schools and colleges indicating acceptance into a particular program are subject to official admission to the institution. Applicants who do not receive official notification of admission within a reasonable period of time after submitting application materials should contact the Office of Admissions and Records, (303) 629-2660.

II. TUITION AND FEES, EXPENSES, AND FINANCIAL ASSISTANCE

Tuition and Fees

All tuition and fee charges are established by the Board of Regents, the governing body of the University of Colorado, in accordance with legislation enacted annually (usually in the spring) by the Colorado General Assembly. The regents reserve the right to change tuition and fee rates at any time. A tuition schedule is published prior to registration for each term, and students should contact the Office of Admissions and Records for further information on the tuition and fee charges for a particular term. The rates below were effective for the 1976-77 academic year and are provided to assist prospective students in anticipating cost.

TUITION RATES FOR 1976-77

Credit Hours of Enrollment	*Resident*	*Nonresident*
0 - 3	$ 54	$126
3.1- 4	72	168
4.1- 5	90	210
5.1- 6	108	252
6.1- 7	126	727
7.1- 8	144	727
8.1- 9	162	727
9.1-18	182	727
For each hour over 18	additional 12	additional 48.50

OTHER FEES

1. *Student activity fee* (mandatory for all students):

Fall semester 1977	$13
Spring semester 1978	$13
Summer term 1978	$ 9

2. *Matriculation fee* (mandatory for all new students):

Degree students	$15
Special students	$ 5

This is a one-time nonrefundable fee charged at the time of initial registration. No further charges will be made for adding or dropping courses or for ordering transcripts. A special student who becomes a degree student will be charged $10 at the initial registration as a degree student.

3. *Health insurance fee* (automatic for all students unless waived):

Fall or spring semester	$33.75
Summer term	$25.75

Health insurance coverage is automatic unless waived by the student by signing a waiver card and turning it in at the time of registration. Dependent coverage (spouse and/or children) is also available at an additional charge. Further information on health insurance is available from the Office for Student Affairs, 629-2861.

4. *Doctoral dissertation fee* (mandatory for all students certified by the Graduate School for enrollment for doctoral dissertation):

Dissertation fee	$72

5. *Comprehensive examination fee* (mandatory for graduate student enrolled for a comprehensive examination only):

Examination fee	$45

Graduate students enrolled for a comprehensive examination will be assessed regular tuition and fees if they need hours toward graduation.

6. *Laboratory breakage fee* (mandatory for students enrolled in a chemistry laboratory course):

Breakage deposit	$10

This fee will be refunded at the end of the term if appropriate.

7. *Music facilities fee* (mandatory for College of Music students and others enrolled in certain music courses):

Music fee	$18

College of Music students and others enrolled in piano, sound recording and reinforcement, and electronic music must pay this fee. No student is charged more than one $18 fee.

PAYMENT OF TUITION AND FEES

All tuition and fees are assessed and payable when the student registers for the term. Arrangements may be made through the Finance Office at the time of registration to defer payment of part of the charges. A minimum down payment consisting of the resident tuition for 0-3 hours or one-third of the total tuition, whichever is greater, must be made at the time of

registration. Specific information on deferred payment is included in the *Schedule of Courses* published before each semester or summer term.

Students who register for courses are liable for payment of tuition and fees even though they may drop out of school. Refund policies for students who withdraw from the University are included in the *Schedule of Courses.* A student with financial obligations to the University will not he permitted to register for any subsequent term, to be graduated, or to be listed among those receiving a degree or credit. The only exception to this regulation involves students with loans and other types of indebtedness which are payable after graduation.

Personal checks are accepted for any University obligation. Any student who pays with a check which is not acceptable to the bank may be immediately dropped from the rolls of the University.

Residency Classification for Tuition Purposes

General Policies. A student is initially classified as a resident or nonresident student for tuition purposes at the time of application to the University. The classification is based on information furnished by the student and other relevant sources. To be eligible for in-state, or resident, status the following requirements (as defined in the Colorado Revised Statutes, Chapter 124, Article 18) must be met by students who are 21 years of age or older (or emancipated minors as defined by law): (1) the student must have been domiciled in Colorado for 12 consecutive months preceding the date of registration for the term in which in-state status is desired; (2) the student must demonstrate significant intent to make Colorado a fixed and permanent residence. Intent is demonstrated by compliance with other mandatory laws of the state (i.e., valid driver's license, valid motor vehicle registration, payment of state income tax, etc.). An unemancipated minor assumes the domicile of his or her parents.

Once the student's status is established, it remains unchanged unless satisfactory information to the contrary is presented. A student who, due to subsequent events, becomes eligible for a change in classification from resident to nonresident or vice versa must inform the Office of Admissions and Records within 15 days after such a change occurs. An unemancipated minor whose parents move their residence outside of the state is considered a nonresident student from the date of the move and will be charged nonresident tuition at the next registration. The student or his or her parent is required to notify the Office of Admissions and Records in writing within 15 days after such a change occurs. Similarly, an adult student or emancipated minor who moves outside of Colorado must send written notification to the Office of Admissions and Records within 15 days of the change.

Petitioning for a Change in Residency Classification. Any student who is 21 years of age or older, or an emancipated minor as defined by law, may change his or her residence and tuition classification status. Detailed information on the procedures which must be followed, including necessary petition forms, is available from the Office of Admissions and Records. Petitions will not be considered until an application for admission and supporting credentials have been received by the University. Changes in classification are effective at the time of the student's next registration. A student who willfully gives wrong information in order to avoid paying out-of-state tuition is subject to legal and disciplinary action.

Estimated Expenses

Educational expenses at UCD include tuition, fees, and the cost of books and related instructional materials. Students who do not live with their parents must also include the cost of housing and food expenses. All students should consider transportation and personal expenditures (i.e., clothing, entertainment, etc.) in determining their expenses. The following table gives an estimate of how much it will cost to attend UCD full time for an academic year. The figures given are only estimates and may vary considerably according to the individual student's life style.

1977-78 ESTIMATED EXPENSES FOR AN ACADEMIC YEAR

(FULL TIME STUDENT, FALL AND SPRING SEMESTERS)

Single Student	*Resident Living With Parents*[1]	*Resident Not Living With Parents*	*Nonresident*
Tuition and fees	$ 390	$ 390	$1,480
Room at $110/month		990	990
Food at $70/month		630	630
Personal at $61/month	550	550	550
Books and supplies	200	200	200
Transportation	300	300	300
TOTAL	$1,440	$3,060	$4,150
Married Student			
Tuition and fees	$ 390	$ 390	$1,480
Room at $180/month		1,620	1,620
Food at $110/month		990	990
Personal at $90/month	810	810	810
Books and supplies	200	200	200
Transportation	400	400	400
TOTAL[2]	$1,800	$4,410	$5,500

[1]Room and board are not included.
[2]Additional expenses for children should be estimated as follows: $630/first child, $540/second child, and $450/third child.

Financial Assistance

UNDERGRADUATE STUDENTS

All questions and correspondence regarding financial assistance for undergraduate students, including requests for applications for financial aid, should be directed to:

Office of Financial Aid
University of Colorado at Denver
1100 Fourteenth Street
Denver, Colorado 80202
(303) 629-2886

Types of Aid Available

The financial aid program for undergraduate students at UCD who have not yet received a baccalaureate degree is designed to help students who without such aid would be unable to attend the University. There are four basic types of aid available, funded by the federal government, the state, and private sources.

Grants. Grants are awards based on the financial need of the student and do not require repayment. Basic Educational Opportunity Grants, Supplemental Educational Opportunity Grants, State Student Incentive Grants, Colorado Student Grants, and Colorado Graduate Grants are available at UCD.

Loans. Loans are made to the student at low interest rates. Loans must be repaid, usually after graduation or upon leaving the University. Loans available are National Direct Student Loans and short-term emergency loans.

Work/Study Program. The work/study program provides jobs and income to students who without this aid could not attend the University.

Scholarships. Scholarships are awards based on academic merit, not on financial need. They do not require repayment. The scholarship funds are available through the Colorado Scholars Program.

How and When to Apply

To apply for the above types of financial aid, a student must obtain the required application forms (described below) from the Office of Financial Aid or the high school counselor. Applications for financial aid are not sent routinely with applications for admission, and the student must request such forms separately. Because requests for financial assistance exceed available funds, applications should be completed and returned to the Office of Financial Aid as early as possible. For maximum consideration, the following deadlines should be observed:

March 1. Applications for aid for the following academic year should be submitted by entering freshmen and transfer students.

April 1. Applications for aid for the following academic year should be submitted by continuing students.

October 1. Applications for aid for the spring semester should be submitted by all students.

The following forms must be completed:

1. For Grants, Loans, and the Work/Study Program:

a. *UCD Application for Financial Aid.* (Available from the Office of Financial Aid.) This is the basic form which must be completed by all undergraduate students applying for grants, loans, and the work-study program.

b. *Family Financial Statement.* (Available from the Office of Financial Aid or high school counselor.) This form is used to determine how much financial support the student's family can provide. All students must complete this form or complete an "Affidavit of Nonsupport," which is provided with the UCD Application for Financial Aid. The Family Financial Statement is processed by the American College Testing Program, which sends the results to the institution(s) to which the student is applying. This form should be completed by February 1 to reach the Office of Financial Aid at UCD by March 1.

c. *Basic Educational Opportunity Program Grant Application.* (Available from the Office of Financial Aid or the high school counselor.) This form must be completed by all undergraduate students applying for financial aid at UCD. Applications should be mailed by March 1 to the federal processor. Notification of student eligibility for a grant is usually mailed to the applicant within a month of application. The notification, whether or not a grant has been awarded, should be sent to the Office of Financial Aid.

2. *For Scholarships.* Entering freshman and transfer students should contact the Office of Admissions and Records, (303) 629-2660, in February for information and applications for the Colorado Scholars Program. Continuing students should contact the Office of Financial Aid in February, (303) 629-2886.

Notification and Period of Awards

Applicants are usually notified of financial aid awards for the next academic year in May. The award notice usually includes a "package" of financial assistance geared to the student's needs, and may include scholarships, grants, loans, work/study, or some combination of these. Students who do not receive notification in May should contact the Office of Financial Aid.

Awards are made for a maximum period of one year and must be renewed annually. Students will not be granted an award until they are officially admitted to UCD as degree students.

Academic Requirements

Students receiving the above types of financial assistance must demonstrate that they are maintaining normal academic progress toward a degree and are in good standing at the University. Students must be full time (undergraduate students—minimum of 12 credit hours per semester, graduate students—minimum of 8 credit hours per semester) if they wish to be considered for aid to cover expenses other than tuition, fees, and books.

Other Types of Assistance

In addition to the four basic types of financial assistance described above, several other programs are available. Some of the colleges and schools have individual scholarship programs, and there are specialized programs available, including the Bureau of Indian Affairs Grant Program, the Law Enforcement Educational Program, ROTC scholarship and loan programs, and Veterans' Affairs scholarship and loan programs. The Office of Financial Aid also provides short-term emergency loans and assists students in finding part-time employment. Contact the Office of Financial Aid or other appropriate office if you want more information on any of these programs.

GRADUATE STUDENTS

All correspondence and questions regarding loans and the work/study program available to graduate students should be directed to the Office of Financial Aid, 1100 Fourteenth Street, Denver, Colorado 80202, (303) 629-2886. All correspondence and questions regarding graduate fellowships, scholarships, Colorado Graduate Grants, teaching assistantships, instructorships, and research assistantships should be directed to the individual graduate department.

Graduate students are eligible for the loan program and the work/study program described in the preceding section for undergraduates. The application procedures and other requirements are basically the same. Graduate students should obtain the necessary application materials from the Office of Financial Aid and submit materials in accordance with the deadlines given earlier. Graduate students must fill out the basic UCD Application for Financial Aid and complete the Family Financial Statement or the Affidavit of Nonsupport. In addition, graduate students must submit a Graduate Information Sheet to their department which is forwarded to the Office of Financial Aid. Graduate students are also eligible for short-term emergency loans, part-time employment counseling, and other specialized awards such as the Law Enforcement Educational Program, and ROTC and Veterans' Affairs scholarships and loans. Interested students should contact the Office of Financial Aid or other appropriate office for more information.

Graduate students are eligible for financial assistance in the form of part-time instructorships, teaching assistantships, research assistantships, Colorado Graduate Grant, scholarships, and fellowships. More information on these programs is included in this bulletin in those sections on the Graduate School, the Graduate School of Public Affairs, and the College of Environmental Design. Information on application procedures and deadlines is available from the individual graduate departments.

III. REGISTRATION: SELECTING A PROGRAM AND COURSES

Selecting a Program and Courses

New and continuing UCD students are urged to review Section VI and the following sections of this bulletin. Section VI describes the traditional and nontraditional instructional programs available at UCD, and the sections which follow it give information by school or college on the various majors available, course requirements by major, graduation requirements, course load policies, and other information and specific policies. A review of this information will not only acquaint students with the many programs available, but will also assist them in planning a program for each semester. Courses available during a particular semester or summer term are listed in the *Schedule of Courses,* published several weeks before registration and available from the Office of Admissions and Records and the various deans' offices.

Undergraduate students who need assistance in planning a program or selecting courses should contact the college or school in which they are enrolled to arrange for a counseling appointment. The appointment should be made prior to registration. Graduate students should contact their graduate department for assistance.

Orientation

An orientation program for all new students is held at the beginning of the fall semester, usually on the same day as registration. The program is conducted by the Office for Student Affairs and introduces the programs, activities, and services available at UCD, in addition to providing information on degree requirements, how to register, and similar matters.

Registration

GENERAL PROCEDURES

Registration for new students is held the week before classes begin on the dates indicated in the Academic Calendar in this bulletin. Continuing students usually register during the prior term. Registration information is given in the *Schedule of Courses,* published several weeks before registration and available from the Office of Admissions and Records and the various deans' offices. Only students who have been accepted for enrollment for a particular term may register for courses.

LATE REGISTRATION

Late registration dates are indicated in the Academic Calendar in this bulletin. Students who register late may be charged a fee and may have difficulty enrolling in the courses they want because of limited space.

PAYMENT OF TUITION AND FEES

All tuition and fees are assessed and payable at registration. Arrangements may be made with the Finance Office at the time of registration to defer payment of a portion of the charges with a minimum down payment or one-third of the tuition, whichever is greater. Specific information on deferred payment is included in the *Schedule of Courses.*

INTER-INSTITUTIONAL REGISTRATION

UCD students may register for courses offered by Metropolitan State College and the Community College of Denver-Auraria with approval of their dean. Refer to the *Schedule of Courses* for more information.

Adding and Dropping Courses

All schedule changes must be made on a Change of Schedule card. No changes will be made until the card with required signatures is returned to the Office of Admissions and Records.

ADDING COURSES

Courses may not be added after the second week of classes except under unusual circumstances with approval.

DROPPING COURSES

Courses may be dropped during the first two weeks of classes, and no signatures are required. After the second week, the instructor must certify that the student is passing the course if it is to be dropped without discredit. After the tenth week, courses may not be dropped except under circumstances beyond the student's control (accident, illness, etc.) and with written approval of the instructor and the dean. Students who do not officially drop a course will receive a grade of *F* in the course. Please refer to the current *Schedule of Courses* for information regarding tuition charges for dropped courses.

IV. ACADEMIC POLICIES AND REGULATIONS

Advanced Standing and Advanced Placement Credit

Undergraduate students may obtain credit for lower-level courses in which they demonstrate proficiency by examination. By passing an examination, the student will be given credit for the course to satisfy lower division requirements and may be eligible to enroll in higher level courses than indicated by the student's formal academic experience. Credit granted for courses by examination is treated as transfer credit without a grade but does count toward graduation and other requirements for which it is appropriate. There are three types of examinations as described below.

ADVANCED PLACEMENT PROGRAM

The Advanced Placement Program of the College Entrance Examination Board (CEEB), allows students to take advanced work while in high school and then be examined for credit at the college level. Students who take advanced placement courses and subsequently receive scores of 3, 4, or 5[1] on the CEEB Advanced Placement Examination are given college credit for lower-level courses in which they have demonstrated proficiency and are granted advanced standing in those areas. Students with scores below 3[1] are considered for advanced placement by the discipline concerned. For more information, contact your high school counselor or the Office of Admissions and Records.

CREDIT BY EXAMINATION

Students may receive credit by examination for work completed by private study or through employment experience. To qualify for an examination, the student must be formally working toward a degree at UCD and have a grade-point average of at least 2.0. Examinations are arranged through the Office of Admissions and Records, and a nonrefundable fee is charged. Students should contact the office of the dean of the college or school in which they are enrolled.

COLLEGE-LEVEL EXAMINATION PROGRAM

An exciting challenge is available to incoming UCD students who may earn University credit by examination in subject areas in which they have excelled at college-level proficiency. Interested students are encouraged to take appropriate subject examinations provided in the College-Level Examination Program (CLEP) of the College Entrance Examination Board testing service. The cost for a single examination is $20.

Students who wish to challenge subject areas for credit are urged to contact the offices of their school or college to determine which courses may be applied to graduation requirements.

Policies of the colleges regarding which subjects may be challenged are as follows:

Liberal Arts and Sciences. Students who plan to graduate from the college or to enroll in the college to fulfill lower division requirements for the professional schools may earn college-level credit in the following CLEP subject areas:

American Literature	Introductory Economics
Analysis and Interpretation of Literature	Western Civilization
English Literature	Biology
American Government	General Chemistry
American History	Geology
General Psychology	Introductory Calculus

Business and Administration. CLEP credit is most appropriate for prebusiness requirements and nonbusiness electives. A maximum of 6 hours of credit in any one course area will be allowed, and CLEP examinations may not be taken in areas where credit has already been allowed. CLEP credit may be allowed for business course requirements only with prior written approval of the dean and division head. Specific information is available in the Office for Student Affairs, Room 602.

Engineering and Applied Science. Credit earned by CLEP examination must be within the number of elective hours specified by the individual department.

[1]Students in the College of Engineering and Applied Science must receive scores of 4 or 5 for credit to be granted; students with scores of 3 may be considered by the department concerned. All credit must be validated by subsequent academic performance.

Twenty-three subject areas in the fields of computing, business, science, mathematics, the humanities, and the social sciences may be challenged. A list is available from the dean's office, Room 405B.

CLEP subject examinations are administered monthly at UCD. Students seeking further information or wishing to register for CLEP tests should contact Paula Rosen, Testing Supervisor, at 629-2861 or in Room 310.

Colorado residents may obtain CLEP materials from the regional office or the test center located nearest to the student's high school.

Regional Office:

College Level Examination Program
c/o College Entrance Examination Board
2142 South High Street
Denver, Colorado 80210

Test Centers:

Metropolitan State College, Denver
Colorado State University, Fort Collins
El Paso Community College, Colorado Springs
University of Southern Colorado, Pueblo
University of Denver, Denver
Fort Lewis College, Durango
University of Colorado at Boulder
University of Colorado at Denver
University of Colorado at Colorado Springs

Students living outside of Colorado may obtain CLEP materials by writing:

Institutional Testing Department
College Level Examination Program
Box 1822
Princeton, New Jersey 08540

Credit for Courses Taken at Other Institutions

Undergraduate transfer credit for courses taken at other collegiate institutions will be accepted upon approval by the Office of Admissions and Records, the school or college concerned, and/or the major department. In general, UCD will accept transfer credits insofar as they meet the degree, residence, and other requirements of the student's program at UCD. For transfer credit to be considered, the course work must have been taken at a college or university of recognized standing and a grade of *C* or higher must have been earned. A maximum of 72 semester credit hours (or 108 quarter credit hours) of junior college work may be applied toward the requirements for the baccalaureate degree. No credit is allowed for vocational/technical, remedial, or religious/doctrinal courses. A maximum of 60 semester hours of extension and correspondence work (not to include more than 30 semester hours of correspondence) may be allowed if the above conditions are met. Transfer credit is not included in a student's grade-point average but does count toward graduation and other requirements for which it is appropriate.

The College of Business and Administration has its own policies on the transfer of credit. The college generally limits transfer credit for business courses to those taken at the lower division level. All courses in the area of emphasis must be taken at the University of Colorado unless written approval is obtained from the division head. A maximum of 60 semester hours of junior college work and 9 semester hours of business courses taken through correspondence study may be applied toward baccalaureate degree requirements. All correspondence courses are evaluated to determine their acceptability, and required business courses and those in the area of emphasis may not be taken through correspondence.

Credit for Independent Study

Undergraduate students may register for independent study projects with written approval by the dean of the college or school and the appropriate faculty member. A maximum of 3 semester hours of credit may be given for independent study per semester. Policies on the application of independent study credit toward baccalaureate degree requirements are:

College of Liberal Arts and Sciences	Maximum of 12 semester hours
College of Business and Administration	Maximum of 6 semester hours, including courses in experimental studies
College of Music	Variable

Credit for Military Service, Schooling, and ROTC

MILITARY SERVICE AND SCHOOLING

Applicants with military experience should submit the following with their application in order to have credit for service and education evaluated: (1) copies of discharge and separation papers, and (2) DD Form 295, "Application for the Evaluation of Educational Experience During Military Service" (USAF personnel will furnish an official transcript from the community college at the appropriate Air Force facility). Credit will be awarded as recommended by the Commission on the Accreditation of Service Experiences of the American Council on Education to the extent that such credit is applicable to the degree sought at UCD. Credit for courses completed through the U.S. Armed Forces Institute will be evaluated on the same basis as transfer credit from collegiate institutions (see above).

RESERVE OFFICERS' TRAINING CORPS (ROTC)

Students enrolled in Army or Air Force ROTC programs should consult with their college or school regarding the application of ROTC course credit toward graduation requirements. The College of Liberal Arts and Sciences allows a maximum of 12 semester hours of ROTC credit to be applied toward baccalaureate degree requirements. The College of Business and Administration stipulates that ROTC courses may be used for credit only for nonbusiness

elective requirements and that no credit may be given for freshman and sophomore ROTC courses. Furthermore, a maximum of 12 semester hours may be applied toward baccalaureate degree requirements and only if the ROTC program is completed.

Grading System and Policies

The following information applies only to undergraduate students. Graduate students should refer to the sections of this bulletin on the Graduate School, the Graduate School of Public Affairs, and the College of Environmental Design, or contact the appropriate dean's office for information.

UNIFORM GRADING SYSTEM

Grades awarded by all undergraduate colleges and schools of the University are:

A—4 grade points per credit hour; superior
B—3 grade points per credit hour; good
C—2 grade points per credit hour; fair
D—1 grade point per credit hour; minimum passing
F—0 grade points per credit hour; failing

The instructor is responsible for determining the requirements for whatever grade is assigned. The cumulative grade-point average is computed by dividing the total number of credit points earned by the total number of hours attempted. For example, a student earning a grade of *A* for 6 credit hours, *B* for 6 credit hours, *C* for 4 credit hours, and *F* for 1 credit hour would compute his or her GPA as follows:

(A) 4 grade points × 6 credit hours = 24
(B) 3 grade points × 6 credit hours = 18
(C) 2 grade points × 4 credit hours = 8
(F) 0 grade points × 1 credit hour = 0

17 credit hours = 50 grade points
50 grade points divided by 17 credit hours = 2.94 GPA

Additional Symbols

In place of the grades indicated above, the instructor may assign one of the following:

I/F (Incomplete/Failing). This grade is assigned when the instructor has insufficient information to assign a final grade but the work presented is of failing quality. The *I/F* grade will be automatically converted to an *F* grade after one academic year if the work is not made up by the student.

I/W (Incomplete/Withdrawal). This grade is assigned when the instructor has insufficient information to assign a final grade but the work presented is of passing quality. The *I/W* will be automatically converted to a *W* (see below) grade after one academic year if the work is not made up by the student. A grade of *W* is not included in the grade-point average, and the student receives no credit for the course.

W (Drop Without Discredit). This grade is given when a student officially withdraws from a course or when a student fails to make up work in which a grade of *I/W* (see above) has been previously given. The *W* grade is not included in the grade-point average, and the student receives no credit for the course.

P (Pass). This grade is awarded to students who pass courses taken on a pass/fail basis and may be awarded to students enrolled in honors courses who do not qualify for a grade of *H (Honors).* A grade of *P* is not included in determining the grade-point average, but credit for the course does apply toward graduation requirements.

H (Honors). This grade is awarded to students who complete honor courses with distinction. A grade of *H* counts toward graduation requirements, but is not included in the grade-point average calculation.

NC (No Credit). This grade is awarded to students enrolled in courses on an audit/no grade basis. A grade of *NC* does not count toward graduation requirements and is not included in the grade-point average calculation.

Y. This grade is used to indicate that an entire grade roster was not received by the Office of Admissions and Records by the time grades were processed. A grade of *Y* is converted to a new grade when adequate information has been received.

GOOD STANDING

To remain in good standing within a particular discipline, a student must maintain a minimum grade-point average of 2.0 *(C)* in all course work attempted. A minimum grade-point average of 2.0 must also be maintained to qualify for an undergraduate degree. Policies on academic probation, suspension, and dismissal vary by college or school, and students should refer to the sections of this bulletin dealing with the colleges and schools for information.

PASS/FAIL OPTION

The pass/fail option is designed to give students an opportunity to enroll in challenging courses without jeopardizing their scholastic record. Subject to the policies of the individual college or school, students may enroll for courses on a pass/fail basis during registration. Changes to or from *pass/fail* must be made during the two-week drop/add period after classes begin. After two weeks, changes may be made only with approval by the dean.

Up to 16 semester hours of regular course work may be taken on a pass/fail basis and credited toward the requirements for a baccalaureate degree. Not more than 6 semester hours of course work may be taken on a pass/fail basis in any semester. Grades of *D* or better earned in a course taken on a pass/fail basis are converted to a *P* (pass) grade. Grades below *D* are converted to an *F* (fail) grade. A grade of *P* is not included in determining the student's grade-point average; a grade of *F* is included.

Specific policies of the colleges regarding the pass/fail option follow.

PASS/FAIL OPTION RESTRICTIONS

College	*General*	*16 Hours Maximum*	*Transfer Students*
Liberal Arts and Sciences	May be restricted in certain majors; not included in 30 hours of *C* or better work required for major	Does not include courses taken in honors, physical education, cooperative education, and certain teacher certification courses	May not be used by students graduating with only 30 semester hours taken at the University
Business and Administration	May not be used for "core" courses required for graduation and courses in area of emphasis	Includes credit received through CLEP and advanced standing examinations	Maximum of 1 semester hour of *pass/fail* for every 8 semester hours attempted at the University
Engineering and Applied Science	Courses must be designated by major department; students without major not eligible; recommended maximum — one course/semester	Includes courses taken in the honors program	Maximum of 1 semester hour of *pass/fail* may be applied toward graduation for every 9 semester hours taken in the college
Music	Same as business	Includes courses taken in the honors program	

Inspection of Education Records

Periodically, but not less than annually, the University of Colorado informs students of the Family Educational Rights and Privacy Act of 1974. This act, with which the institution intends to comply fully, was designated to protect the privacy of education records, to establish the right of students to inspect and review their education records, and to provide guidelines for the correction of inaccurate or misleading data through informal and formal hearings. Students also have the right to file complaints with the Family Educational Rights and Privacy Act Office (FERPA) concerning alleged failures by the institution to comply with the act.

Local policy explains in detail the procedures to be used by the institution for compliance with the provisions of the act. Copies of the policy can be found in the library on each of the several campuses of the University of Colorado.

A directory of records which lists all education records maintained on students by this institution may be found in the offices of the chancellor on each campus.

The following items of student information have been designated by the University of Colorado as public or "directory information." Such information may be disclosed by the institution for any purpose, at its discretion. These items are: name, address, telephone number, dates of attendance, registration status, class, major field of study, awards, honors, degree(s) conferred, past and present participation in officially recognized sports and activities, physical factors (height, weight) of athletes, date and place of birth.

Currently enrolled students may withhold disclosure of any category of information under the Family Educational Rights and Privacy Act of 1974. To withhold disclosure, written notification must be received in the Office of Admissions and Records on the appropriate campus prior to the 11th day of classes in any given term. Forms requesting the withholding of "directory information" are available in the Offices of Admissions and Records.

The University of Colorado assumes that failure on the part of any student to request specifically the withholding of categories of "directory information" indicates individual approval for disclosure.

Questions concerning the Family Educational Rights and Privacy Act may be referred to the Office of Admissions and Records.

Student Classification

Students who have passed fewer than 30 semester hours are classified as freshmen. To be classified as a sophomore, a student must have passed 30 semester hours; to be classified as a junior, 60 hours; and to be classified as a senior, 90 hours of credit. All transfer students will be classified on the same basis according to their hours of credit accepted by the University of Colorado.

Student Indebtedness

A student with financial obligations to the University will not be permitted to register for any subsequent term, to be graduated, or to be listed among those receiving a degree or credit from the University. The only exception to this policy involves students who have loans or other types of indebtedness which mature after graduation.

Withdrawal From the University

A student who wishes to withdraw from the University must obtain written approval from the Office of Admissions and Records and the appropriate dean's office. Withdrawal forms are available from the deans' offices. A student may withdraw with grades of *W* within two weeks of the beginning of the term. After the second week of classes, appropriate *I/F* or *I/W* grades will be assigned. After the tenth week of

the term, a student will not be allowed to withdraw except under circumstances clearly beyond the student's control. Policies on charges and refunds for students who withdraw are given in the *Schedule of Courses* published prior to each term.

A student who ceases to attend classes without officially withdrawing from the University will receive a grade of *F* for all course work enrolled for during that term.

V. SERVICES FOR STUDENTS

The Division of Student Affairs offers educational and personal support services and programs designed to assist students in meeting their educational and personal growth objectives. The division office telephone number is 629-2861.

Academic Honorary Societies

Academic honorary societies are affiliated with each of the schools and colleges. Further information may be obtained from the deans' offices.

Alumni and Friends Program

The UCD Alumni and Friends organization was established in 1975 to support the University of Colorado at Denver in its programs. Membership is open to all University of Colorado graduates, former students, and friends. Activities include an annual reception for UCD graduates, assistance with the UCD Teacher Recognition Award program, an urban-oriented forum each spring, a bimonthly newsletter, and general support of the various colleges and schools of UCD.

An annual meeting is held each spring for all UCD alumni and friends at which officers and directors are elected and plans are made for the coming year. The organization also participates in the CU Alumni Coordinating Council which meets periodically on University-wide topics. The office telephone number is 629-2665.

Counseling Center

The services of the Counseling Center are open to all students and prospective students. Personal and vocational counseling, group experiences, and testing are provided by trained counselors. Interviews are confidential and there is no fee for counseling. The office telephone number is 629-2861.

Disabled Student Services

Disabled Student Services handles the special needs of physically handicapped students, helping them to obtain a university education. Services include orientation programs, registration assistance, and the assignment of reserved parking spaces to students with serious physical impairments. The office telephone number is 629-2861.

Educational Opportunity Programs

The Educational Opportunity Programs assist all educationally disadvantaged students at UCD. Support programs include specialized recruiting, intensive counseling, tutorial services, and community outreach programs. Departments include the Asian American Program, Black Education Program, Mexican American Education Program, Native American Education Program, and the Tutorial Center. Telephone, 629-2700.

Educational Opportunity Program/ Special Services

The Educational Opportunity Programs/Special Services project provides academic aid to low-income, educationally disadvantaged, and physically handicapped students who meet federal guidelines. For more information, refer to Educational Opportunity Program/Special Services in the College of Liberal Arts and Sciences section of this bulletin.

Health Insurance Program

The student medical-hospital-surgical plan is automatic for all students unless waived. Dependent coverage is available at an additional charge. Students may waive this coverage by signing a waiver card and returning the card at the time of registration.

International Student Services

The Office for Student Relations provides assistance to the more than 300 international students who attend UCD. The office helps foreign students with such requirements as immigration certifications and passport assistance, and supplies information on study abroad programs, international student I.D. cards, and overseas travel.

Student Conduct, Policies, and Standards

The Office for Student Relations, which protects student rights and responsibilities, administers the Code of Student Conduct. When a student enrolls in the University she or he agrees to participate meaningfully in the life of the University and to share in the obligation to preserve and promote its educational endeavors. Each student preserves his or her rights as a citizen and has a basic obligation not to commit or to tolerate any impingement on the rights of others. Copies of the code and information regarding all student grievance procedures may be obtained in the Office for Student Relations. Telephone, 629-2861.

Student Employment Opportunities

The Office of Financial Aid offers job listings to all enrolled UCD students. Both on-campus and off-campus job openings are listed.

Students receiving financial aid may use this service only if the Office of Financial Aid has determined that earnings from the job in question will not exceed the amount of their unmet need. Telephone, 629-2886.

For information on career-related job opportunities, refer to Cooperative Education under Academic Programs.

Tutorial Center

The center is based upon the concept that all University students should have the opportunity to fully develop the skills necessary to meet their educational objectives. Programs are provided for general improvement of study habits and for specific assistance with particular subject areas. For further information refer to the Tutorial Center portion in the College of Liberal Arts and Sciences section of this bulletin. Telephone, 629-2803.

Veterans Affairs

The Office of Veterans Affairs offers all student veterans counseling regarding school attendance requirements, benefits, personal and vocational assistance, and other program information. Consult the veterans representative, 629-2630.

Women's Center

The Women's Center provides counseling regarding vocational choices and personal and school-related problems. The center is also a place to meet other women students or join a discussion group. Telephone, 629-2815.

VI. ACADEMIC PROGRAMS

Degree Programs

For complete bachelor's and master's degree programs offered by UCD, see page 2.

UCD also offers preprofessional programs in law, journalism, and the health sciences (child health associate, dental hygiene, dentistry, medical technology, medicine, nursing, optometry, osteopathy, pharmacy, and physical therapy). Courses in many other undergraduate and graduate areas are offered at UCD, but degrees must be completed at the University of Colorado at Boulder. All academic programs are administered by eight separate colleges and schools:

College of Liberal Arts and Sciences
College of Business and Administration and Graduate School of Business Administration
School of Education
College of Engineering and Applied Science
College of Environmental Design
College of Music
Graduate School
Graduate School of Public Affairs

The remaining sections of this bulletin discuss in detail each school and college and provide information on their specific policies on requirements for graduation, course requirements for various majors, course load policies, and similar information. Course offerings appear in a separate section beginning on page 111.

Cooperative Education Program

1047 Ninth Street
629-2892

The Cooperative Education Program provides undergraduate students with an opportunity to gain work experience relevant to their academic programs. The program is open to all students who have completed their freshman year and have maintained a grade-point average of at least 2.5. The cooperative internship program consists of jobs developed by the program staff in a wide variety of federal, state, and private agencies and businesses. Positions are specifically geared to students' academic and career goals. Students who work for the federal government usually work and attend school during alternate semesters. Students who work for private agencies and businesses usually work part time and attend school part time. Students enrolled in the College of Liberal Arts and Sciences are eligible to receive credit for preprofessional or professional work experience (see the College of Liberal Arts and Sciences section of this bulletin).

Educational Opportunity Program

Room M110A, 1100 Fourteenth Street
629-2701

The Educational Opportunity Program is designed to provide assistance to minority students and to acquaint students with the history and culture of Asian Americans, Blacks, Mexican Americans, and Native Americans. Student organizations provide assistance with recruitment, counseling, and tutoring; financial assistance is available through grants and the Work/Study Program. Courses are offered in Asian American, Black, Mexican American, and Native American Studies. These courses are open to all students and are described in the course description section of this bulletin.

Reserve Officer Training Programs

U.S. Air Force Reserve Officer Training Corps (AFROTC):
Folsom Stadium, Gate 3, University of Colorado at Boulder, Boulder, Colorado 80309, 492-8351

U.S. Army Reserve Officer Training Corps (ROTC):
Department of Military Science, University of Colorado at Boulder, Boulder, Colorado 80309, 492-6495

University of Colorado at Denver students may participate in the Air Force ROTC program offered by the University of Colorado at Boulder and the Army ROTC program offered at UCD. The programs enable students to earn a commission in the Air Force or Army while earning a University degree. Both the Army and Air Force ROTC offer four-year programs designed for freshman students and two-year programs for junior students. Graduate students may also enroll in the Air Force two-year program. Both

programs provide financial assistance to students in the junior and senior years, and the Air Force ROTC includes a scholarship program. Students should apply for the four-year program prior to or during their freshman year, and for the two-year program no later than early in the spring semester of their sophomore year.

Senior Citizen Program

UCD's Office of Community-University Relations offers tuition-free classes for persons 60 years of age and over. Senior citizens may register for any class on a noncredit/audit basis as long as space is available. Senior citizens should register and pick up class registration forms in the Graduate School Office, Room 810, UCD Administration Building, and should take the completed forms to the first session of class for the instructor's approval. The form then should be returned to the Graduate School, and a student I.D. card will be issued which entitles senior citizens to the same privileges as regular degree students. For further information call 629-2663.

Study Abroad Programs

An important educational and cultural experience in the form of study in other countries is available to all qualified UCD students. Richard Flood in the Office for Student Relations, 629-2861, is the UCD representative of the Office of International Education located at the University of Colorado at Boulder.

Specific information regarding the details of each program may be obtained from the Office of International Education at Boulder, 492-7741. Opportunities for study abroad are available in Costa Rica, England, France, Germany, Israel, Italy, Japan, and Mexico.

These programs carry resident credit from the University of Colorado. Interested students should contact their academic advisers and the Student Relations Office early in their freshman or sophomore year in order to prepare for study abroad. Information also is available regarding study abroad programs sponsored by other universities and agencies.

Students interested in obtaining the international student I.D. card, or information on charter flights and special vacation study programs, should contact UCD Student Relations.

Division of Continuing Education

Continuing education at UCD provides lifelong learning experiences for people of all ages seeking to attain career and personal development goals and serves a society trying to cope with the problems and realities of rapidly changing patterns of living. UCD's Division of Continuing Education offers a large noncredit program ranging from one-day workshops to certificate programs requiring several years to complete. Classes meet throughout the Denver metropolitan area. Off-campus credit classes are offered in the public schools, Lowry Air Force Base, and Fitzsimons Army Medical Center.

Noncredit programs are open to all adults regardless of previous education or training. Some advanced courses require a background in a specific subject matter area. Examples of these courses include licensing and professional designation refresher courses for engineers, accountants, and life insurance agents. Except in some certificate programs, no grade is awarded upon completion of a course.

Off-campus credit classes supplement the regular academic programs offered at UCD. These special purpose programs include recertification classes for public school teachers, vacation college, and certificate programs for government professionals. Admission requirements and refund policies for off-campus instruction are identical with requirements for enrollment in UCD. Individuals who have never been enrolled on any campus of the University of Colorado usually are admitted to off-campus instruction as special students.

Individuals interested in obtaining a copy of the *Division of Continuing Education Bulletin* or other information may write or call the division office at UCD, 1100 14th Street, 629-2735.

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RICHARD E. WYLIE, Associate Dean, School of Education; Professor of Education. B.Ed., Plymouth State College; M.Ed., Ed.D., Boston University.

The course information contained in the University of Colorado, Denver catalog is on file at the U.S. Commission on Civil Rights.

A Survey of Graduates of the University Without Walls Program at Loretto Heights College 3001 South Federal Blvd. Denver, Colorado 80236

Spring, 1976

I. INTRODUCTION

A. Purpose of the University Without Walls/Loretto Heights College Graduate Survey

The University Without Walls programs began at Loretto Heights College (LHC) in the spring of 1971. At that time there were 18 students enrolled. Over the past five years the program and student enrollment has grown to include more than 200 persons yearly. As of March, 1976 there are 139 UWW students actively enrolled in UWW/LHC including UWW Special Projects. One hundred and sixty-nine (169) persons had graduated with B.A. degrees from Loretto Heights College through the UWW program, as of December, 1975.

The purposes of this study are many. First, the study was undertaken to develop a better understanding of whether UWW graduates have benefited from their experiences with the UWW program and if so, how. It is hoped that this survey will stimulate greater interest in program evaluation and design. Also, the study is directed not only to staff and program planners, but to graduates as well. Perhaps it will provide "the big-or-bigger picture" that graduates can view and compare with their own UWW experiences. Finally, increasing interest in the outcomes of educational programs mandates both traditional and non-traditional programs to study themselves and their effect on students in order to achieve increased effectiveness, accountability, and quality control.

This information will be useful for recruitment and counseling of students during the admissions process, as well as for public relations, fund-raising, and accreditation.

B. Methodology

In conducting this survey, two research methods were used: 1) telephone interviews to local graduates requesting Part I information of the questionnaire which included Demographic, Graduate School, Employment, Community Involvement, and Alumnae Interest questions, and 2) mailed questionnaire which contained Part II of the questionnaire requesting personal and UWW program evaluation information. Out-of-state graduates and local graduates that could not be reached by phone were mailed the entire questionnaire, Parts I & II.

The questionnaire consisted of 49 questions. It focused on seven areas: Part I - Demographic Information, Graduate School, Employment, Community Involvement, Alumnae Interest, and Part II - Program Evaluation and Personal Information. For a sample questionnaire, refer to Appendix A.

Ninety-one or 54% of the graduates responded by phone or mail to Part I of the questionnaire. Sixty-seven or 40% of the graduates responded by mail to Parts I and/or II. The majority of UWW graduates are residing locally. Therefore , telephone interviews to complete Part I of the questionnaire were more successful than the mailed response to Part II.

Interviewing took place from February 18th to 27th, 1976. Questionnaires were sent to local graduates as soon as the telephone interviews were completed. Out-of-state graduates were sent the entire questionnaire between February 18th and 24th. Local graduates that could not be reached by phone were sent complete questionnaires throughout the February 18th to 27th interviewing period.

The cut-off date to return completed questionnaires was March 12, 1976.

II. SUMMARY OF DATA

(The number at the left in parenthesis corresponds to the number on the questionnaire in Appendix A. The percentages that follow are based on the response to each question.)

A. Demographic Information

(5) Areas of Concentration of the UWW Graduates.

Content Areas*	No. of Respondents	%
The Arts	10	11.0
Business and Organization	10	11.0
Communications	7	7.7
The Community	4	4.4
Counseling	20	22.0
Education	13	14.3
Law	1	1.1
Personal Growth	2	2.2
Religion and Philosophy	5	5.5
Women and Minorities	1	1.1
Earth-Related Science	4	4.4
History	3	3.3
Culture	3	3.3
Research and Statistics	1	1.1
Miscellaneous	7	7.7
	91	100.1

(6) Professional Certification (Teacher Certificate, C.P.A., etc.).

	No. of Respondents	%
YES	28	30.8
NO	32	35.2
NO RESPONSE	31	34.0
	91	100.0

If Yes
Received Before UWW - 18, 64.3%
Received After UWW - 10, 35.7% (See Appendix G for list of certifications)

(7) Number of Semesters Graduates Attended UWW.

Semesters	No. of Respondents	%	Average
2	47	52.3	
3	17	19.3	2.95
4	14	15.9	
5	4	4.6	
6	4	4.6	
7 or more	2	2.3	
	88**	99.0	

*Content Areas were defined in the 1974-75 Research Report.
**Base Numbers (and percentages) are dependent on the number of respondents who chose to answer the question. In most cases, a "no response" category was not included.

(8) Number of Graduates Living in Denver Area while Attending UWW.

	No. of Respondents	%
YES	73	86.9
NO	11	13.1
	84	100.0

(9) Number of Graduates who Received Financial Aid to Attend UWW.

	No. of Respondents	%
YES	31	36.5
NO	54	63.5
	85	100.0

(10) a. Number of Graduates who Received Advanced Standing Credit.

	No. of Respondents	%
YES	65	77.4
NO	19	22.6
	84	100.0

b. Number of Credits Received.

No. of Credits	No. of Respondents	%	Average
1-10	7	10.8	
11-20	5	7.7	34.4 credits
21-30	9	13.8	
31-40	10	15.4	
41-50	6	9.2	
51 or more	25	38.5	
unspecified	3	4.6	
	65	100.0	

(11) Number of College/Universities Graduates Attended Before UWW.

No. of Colleges	No. of Respondents	%	Average
1	33	39.3	
2	28	33.3	2.13
3	13	15.5	
4	4	4.8	
5	3	3.6	
6	1	1.2	
7 or more	2	2.4	
	84	100.1	

For names of the different colleges students attended see Appendix B.

(12) Time Period between Prior College and UWW.

Time	No. of Respondents	%	Average
No Time Lapse	30	34.9	
One Semester to 1 Year	4	4.6	5.35
1 - 3 Years	15	17.4	
4 - 6 Years	9	10.5	
7 - 9 Years	9	10.5	
10 - 12 Years	9	10.5	
13 - 15 Years	1	1.2	
15 or more	9	10.5	
	86	100.1	

(13) Age of Student at Time of Enrollment.

Age	No. of Respondents	%	Average
15 - 18	0	0	
19 - 22	19	21.3	35.1
23 - 30	21	23.6	
31 - 40	20	22.5	
41 - 50	18	20.2	
51 and over	11	12.4	
	89	100.0	

(14) Age of Student at Time of Graduation.

Age	No. of Respondents	%
15 - 18	0	0
19 - 22	12	12.8
23 - 30	22	25.5
31 - 40	25	28.9
41 - 50	16	18.6
51 and over	12	14.0
	87	99.8

Note: See question 7 for length of time graduates attended UWW.

(16) Sex.

	No. of Respondents	%
MALE	36	39.6
FEMALE	55	60.4
	91	100.0

(17) Marital Status.

	No. of Respondents	%
Single	26	28.6
Married	53	58.2
Divorced	10	11.0
Separated	1	1.1
Widowed	1	1.1
	91	100.0

(18) Number of Children of Graduates.

No. of Children	No. of Respondents	%
0	29	37.7
1	10	13.0
2	13	16.9
3	13	16.9
4	5	6.5
5 or more	7	9.1
	77	100.1

(20) Ethnicity.

Race	No. of Respondents	%
Anglo	74	84.1
Chicano	5	5.7
Black	5	5.7
Native American	0	0.0
Other	4	4.5
	88	100.0

B. Graduate School Information.

(21) a. Number of Graduates Who Have Applied to Graduate School.

	No. of Respondents	%
YES	37	42.0
NO	51	58.0
	88	100.0

b. Number of Graduates Who Plan to Apply to Graduate School in the Future.

	No. of Respondents	%
YES	30	54.5
NO	11	20.0
Not Sure	14	25.4
	55	99.9

(23) Number of Graduates Who Have Been Accepted to Graduate School.

	No. of Students	%
YES	27	73.0
NO	2	5.4
Not known at this time	8	21.6
	37	100.0

For names of graduate schools see Appendix C.

(24) Number of Graduates Who Have Completed Graduate School.

Five (5% of the respondents)have completed graduate work. The names of the schools and programs are listed in Appendix C.

(25) a. Number of Students Who, If They Had the Opportunity, Would Like to Attend Graduate School (M.A., Ph. D., other) on a UWW Model.

	No. of Respondents	%
YES	71	83.5
NO	12	14.1
Not Sure	2	2.4
	85	100.0

b. Field of Interest Graduates Would Like to Pursue.*

	No. of Respondents	%
Psychology or Counseling	17	28.8
Fine Arts	2	3.5
Theatre	2	3.5
Corrections	1	1.8
Socio-Economic Research	1	1.8
Language	2	3.5
Business and Administration	12	20.3
Student Personnel	2	3.5
Social Work	3	5.1
Library Science	1	1.8
Journalism	1	1.8
Media	1	1.8
Gerontology	1	1.8
Communication	2	3.5
Law	1	1.8
Geology	1	1.8
Not Sure of Field	7	11.9
Planning/Architecture	1	1.8
	59	99.8

C. Employment Information

(26) Number of UWW Graduates Who Were Employed When Entering UWW.

	No. of Respondents	%
YES	59	67.8
NO	28	32.2
	87	100.0

(27) Number of UWW Graduates Employed Now.

	No. of Respondents	%
YES	69	83.1
NO	14	16.9
	83	100.0

For list of UWW graduates occupations see Appendix D.

*These fields of interests are respondents' own categories.

(29) Number of Graduates Who Have Changed Employers Since First Enrolling in UWW.

	No. of Respondents	%
YES	25	38.5
NO	30	46.1
Not Applicable	10	15.4
	65	100.0

(30) Number of Graduates Who Considered This Change an Improvement from Previous Job.

	No. of Respondents	%
YES	35	66.0
NO	7	13.2
Not Applicable	11	20.8
	53	100.0

(31) Number of Graduates Who Felt B.A. Through UWW/IHC Was Instrumental in Improving Their Job Potential.

	No. of Respondents	%
YES	49	72.1
NO	19	27.9
	68	100.0

(32) a. Has Your Salary Increased Since You Have Enrolled in UWW?

	No. of Respondents	%
YES	40	81.6
NO	9	18.4
	49	100.0

b. By How Much?

	No. of Respondents	%
No Response	8	20.0
$1,000 - 2,000	7	17.5
$2,000 - 3,000	5	12.5
$3,000 - 4,000	8	20.0
$5,000 +	12	30.0
	40	100.0

(33) Present Salary of UWW Graduates.

	No. of Respondents	%
$1,000-$4,000	9	16.7
$5,000-$10,000	13	24.1
$10,000-$15,000	19	35.2
$15,000-$20,000	7	13.0
$20,000 +	6	11.1
	54	100.1

D. Community Involvement Information

(34) Graduates Involved in Community Activities - or Organizations.

	No. of Respondents	%
YES	59	69.4
NO	26	30.6
	85	100.0

For a list of organizations graduates are involved in see Appendix E.

(35) a. Graduates Who Have Received Special Awards, Certificates, Publications, Commendations, Honors, Etc.

	No. of Respondents	%
YES	17	24.6
NO	52	75.4
	69	100.0

See Appendix F for a list of awards, etc.

b. Were Learning Experiences at UWW Instrumental in Receiving These Awards, Etc.?

	No. of Respondents	%
YES	11	64.7
NO	4	23.5
Not Applicable	2	11.8
	17	99.0

E. Alumnae Involvement

(37) a. Graduates Interested in Maintaining Involvement with UWW/LHC.

	No. of Respondents	%
YES	84	94.4
NO	5	5.6
	89	100.0

b. Different Ways Graduates Want to be Involved.

	No. of Respondents	%
Receiving a newsletter	66	72.5
Involvement with a committee	18	19.7
Being a Resource Person	29	31.9
Other - adjunct faculty help start graduate program talk with new UWW students	3	3.3

(38) Graduates Interested in Giving Financial Support.

	No. of Respondents	%
YES	6	7.5
NO	74	92.5
	80	100.0

F. Program Evaluation

(40) How Graduates Heard About the University Without Walls.

	No. of Respondents	%
Friend	19	30.2
Media	17	26.9
UWW/LHC Catalogue, Staff, Faculty, Students	19	30.2
Community Resources (Other Colleges, Groups, etc.)	8	12.7
	63	100.0

11

(41) How Respondents Rated and Commented About UWW/LHC Processes.*

a. Admissions

	No. of Respondents	%
Excellent	25	41.0
Satisfactory	35	57.4
Unsatisfactory	1	1.6
Not Applicable	0	0.0
	61	100.0

Comments:

	No. of Respondents	%
1. No Comment	45	73.8
2. Could be more discriminating	3	5.0
3. Admissions to CBTE haphazard	1	1.6
4. Simple and efficient	10	16.4
5. Over long distance discouraging, confusing	1	1.6
6. UWW tends to buy into minority lot & overlook middle and lower class folk	1	1.6
	61	100.0

b. LHC Financial Aid

	No. of Respondents	%
Excellent	9	16.4
Satisfactory	15	27.3
Unsatisfactory	7	12.7
Not Applicable	24	43.6
	55	100.0

Comments:

	No. of Respondents	%
1. No Comment	22	71.0
2. Helpful information-no problems	5	16.1
3. Big debt	1	3.2
4. Not enough information	3	9.7
	31	100.0

*Comments are recorded from those who participated in that particular UWW/LHC process. They do not include those who checked "Not Applicable".

12

c. Registration

	No. of Respondents	%
Excellent	18	29.5
Satisfactory	38	62.3
Unsatisfactory	5	8.2
Not Applicable	0	0.0
	61	100.0

Comments:

	No. of Respondents	%
1. No Comment	46	75.4
2. Smooth, good procedure	5	8.2
3. Poor, time consuming procedure	10	16.4
	61	100.0

d. Degree Planning

	No. of Respondents	%
Excellent	24	39.0
Satisfactory	31	50.8
Unsatisfactory	5	6.7
Not Applicable	2	3.3
	62	100.0

Comments:

	No. of Respondents	%
1. No Comment	39	65.0
2. Good, no problem	10	16.7
3. Could have been better-could have used more help	10	16.7
4. Depends on the interest of the Advisor	1	1.6
	60	100.0

e. Advisement

	No. of Respondents	%
Excellent	40	63.5
Satisfactory	22	34.9
Unsatisfactory	1	1.6
Not Applicable	0	0.0
	63	100.0

Comments:

	No. of Respondents	%
1. No Comment	36	57.1
2. Excellent help, very supportive	18	28.6
3. Could have been better	8	12.7
4. Long Distance was problem	1	1.6
	63	100.0

f. Other UWW Staff Support (Director, Coordinators, Secretaries, etc.)

	No. of Respondents	%
Excellent	49	77.8
Satisfactory	13	20.6
Unsatisfactory	1	1.6
Not Applicable	0	0.0
	63	100.0

Comments:

	No. of Respondents	%
1. No Comment	45	71.4
2. Helpful, inspiring, supportive	15	23.8
3. Criticism of Director	3	4.8
	63	100.0

g. Learning Contracts

	No. of Respondents	%
Excellent	27	42.8
Satisfactory	34	54.0
Unsatisfactory	2	3.2
Not Applicable	0	0.0
	63	100.0

Comments:

	No. of Respondents	%
1. No Comment	47	74.6
2. Need more structure, deadlines	5	7.9
3. Good process, flexible learning process	10	15.9
4. Too much emphasis on good school. Each semester should be evaluated for itself.	1	1.6
	63	100.0

h. Resource Persons and Learning Processes

	No. of Respondents	%
Excellent	34	60.7
Satisfactory	20	35.7
Unsatisfactory	2	3.6
Not Applicable	0	0.0
	56	100.0

Comments:

		No. of Respondents	%
1.	No Comment	34	60.7
2.	Not enough resources available through UWW	5	8.9
3.	Very willing, helpful, no problems	10	17.9
4.	Had my own, so can't evaluate	1	1.8
5.	Resource great, had to scrounge for learning resources	1	1.8
6.	Too much emphasis on credentials of Resource Person	1	1.8
7.	My field was new to UWW so had little specific input from staff, but plenty of interest & concern	1	1.8
8.	Didn't use any	1	1.8
9.	Used IHC people who weren't open to UWW concepts-unpleasant	1	1.8
10.	Resources have consistently gone downhill academically and uphill financially	1	1.8
		56	100.1

i. Loretto Heights College Courses

	No. of Respondents	%
Excellent	13	21.7
Satisfactory	16	26.7
Unsatisfactory	4	6.7
Not Applicable	27	45.0
	60	100.0

Comments:

		No. of Respondents	%
1.	No Comment	22	66.7
2.	Some good, some bad	3	9.1
3.	Not stimulating, too easy, would have liked a better selection	3	9.1
4.	No problems	4	12.1
5.	Teachers good, classmates dull	1	3.0
		33	100.0

j. Advanced Standing Credit

	No. of Respondents	%
Excellent	33	60.0
Satisfactory	14	25.4
Unsatisfactory	3	5.4
Not Applicable	5	9.1
	55	100.0

Comments:

	No. of Respondents	%
1. No Comment	35	70.0
2. Good process, best learning experience	11	22.0
3. Could not get staff together for this	2	4.0
4. Staff does not have large enough range to meet every student's needs and background	1	2.0
5. Depends on advisement process	1	2.0
	50	100.0

k. Learning Segment Evaluation

	No. of Respondents	%
Excellent	29	50.9
Satisfactory	24	42.1
Unsatisfactory	4	7.0
Not Applicable	0	0.0
	57	100.0

Comments:

	No. of Respondents	%
1. No Comment	48	84.2
2. Didn't happen	1	1.8
3. Would have liked more self-evaluation, more autonomy	4	7.0
4. Felt an underlying degree of suspicion	1	1.8
5. Very uncritical--was I really good or did everyone get by that easy	1	1.8
6. Pleased with results	1	1.8
7. Advisor very supportive	1	1.8
	57	100.2

16

l. Transcripts & Transcript Supplements

	No. of Respondents	%
Excellent	19	32.2
Satisfactory	36	61.0
Unsatisfactory	4	6.8
Not Applicable	0	0.0
	59	100.0

Comments:

	No. of Respondents	%
1. No Comment	48	81.4
2. Feel transcript should be evaluated. Should be more official. Employers not familiar with UWW process. Too lengthy.	5	8.5
3. Good, helpful	5	8.5
4. Advisor slow but honest way of recording learning	1	1.6
	59	100.0

m. Degree Review Sessions

	No. of Respondents	%
Excellent	30	52.6
Satisfactory	24	42.1
Unsatisfactory	3	5.3
Not Applicable	0	0.0
	57	100.0

Comments:

	No. of Respondents	%
1. No Comment	44	77.2
2. Very good, challenging	4	7.0
3. People didn't show up	2	3.5
4. Anticlimactic	2	3.5
5. Felt rushed, very demanding, wasn't what I expected	-2	3.5
6. More preparation is needed for a degree review	1	1.7
7. Felt I was accepted too easily	1	1.7
8. Needed a representative of background student is working in	1	1.7
	57	99.8

n. Loretto Heights College Support Services

	No. of Respondents	%
Excellent	15	35.7
Satisfactory	20	47.6
Unsatisfactory	7	16.7
Not Applicable	0	0.0
	42	100.0

Comments:

	No. of Respondents	%
1. No Comments	33	78.6
2. Didn't use them	4	9.5
3. Don't recall any support systems	3	7.1
4. Fine institution	2	4.8
	42	100.0

(42) a. What Expectations did Graduates have of UWW When They Began?

	No. of Respondents	%
1. No Comment	8	12.5
2. Had high expectations, expected a free, open, stimulating learning experience	28	43.7
3. To complete a B.A. degree at a distance	2	3.1
4. Less bureaucracy	2	3.1
5. I expected to get a degree	7	10.9
6. I expected more input from staff in planning and guidance	5	7.8
7. Not sure what expectations were	6	9.4
8. Expected a structured college program	6	9.4
	64	99.9

What Graduates Experienced.

	No. of Respondents	%
1. No Comment	12	19.0
2. It wasn't what I expected, it was a bureaucracy	2	3.2
3. It was what I expected, it was a free and open learning environment that was less restrictive and demanding and it allowed me to do what I wanted to do	28	44.4
4. It wasn't what I expected (structured program). I experienced a college program concerned to meet my own needs planned by me. Learned to conceptualize and put experience into a learning model.	13	20.6

a. continued

	No. of Respondents	%
5. I didn't expect anything but experienced a lot--glad about my experiences	1	1.6
6. I expected to get a degree in a year and got it	4	6.4
7. It wasn't what I expected. It did not live up to my expectations.	3	4.8
	63	100.0

b. What Were Some of the Strengths of the Program?

	No. of Respondents	%
1. No Comment	5	8.1
2. The staff and advisors	15	24.2
3. Support, flexibility, humor, informal atmosphere--lots of self growth	36	58.1
4. Resource people	1	1.6
5. A rapid way to achieve a degree	2	3.2
6. An opportunity for a non-traditional student who has been "out of school"	1	1.6
7. The many supplemental programs and the well presented written material	2	3.2
	62	100.0

c. What Were the Weaknesses of the Program?

	No. of Respondents	%
1. No Comment	15	27.3
2. Lack of community and student involvement	4	7.3
3. Position of UWW at IHC (non-structured program in a structured setting)	4	7.3
4. Director imposing a bureaucracy	2	3.6
5. Long Distance relationship for student off campus--need more contact	2	3.6
6. Disorganized program, meetings unclear and chaotic	8	14.5
7. Lack of support and advice from advisor	5	9.1
8. Need more contact with traditional learning environment to compare two types of programs so one feels he is obtaining an equivilent degree	4	7.3
9. Didn't experience any weaknesses	2	3.6
10. Felt like an outsider, seemed to be an in-group at the office	2	3.6

I9

c. continued

		No. of Respondents	%
11.	High cost of tuition	4	7.3
12.	More staff people needed to have a background in the arts	1	1.8
13.	Degree Review process	1	1.8
14.	Initial information on Advanced Standing and Degree Review not clear	1	1.8
		55	99.9

d. Specific Issues of Concern.

		No. of Respondents	%
1.	No Comment	25	48.1
2.	Lack of student involvement	1	1.9
3.	Need for new director	1	1.9
4.	No specific issues	8	15.4
5.	Seek total credibility so it is not an easy way to buy a degree	6	11.5
6.	Cost	2	3.8
7.	Lack of minority students	1	1.9
8.	Some students need more direction--they weren't getting it	3	5.8
9.	Students must be well motivated and have definite goals	1	1.9
10.	Not sure I was doing what I expected	1	1.9
11.	Communication	2	3.8
12.	Having an adequate staff	1	1.9
		52	99.8

e. Impacts of UWW Experience.

		No. of Respondents	%
1.	No Comment	12	20.0
2.	My experience was a positive, worthwhile growing process. It had made me more self confident and interested in learning	43	71.7
3.	A growing awareness of my community and how to use it	2	3.3
4.	Have more success with my career	3	5.0
		60	100.0

f. Recommendations for the Future.

		No. of Respondents	%
1.	No Comment	16	28.1
2.	More structure is needed for younger student	1	1.8
3.	Try to keep program on original track—keep away from bureaucratic hang-ups that seem nearby—keep it small	12	21.0
4.	Maintain contact with off-campus people	4	7.0
5.	Closer relationship needed between college and UWW student	4	7.0
6.	Suggest students work in groups of five rather than alone	1	1.8
7.	More scholarships	1	1.8
8.	Need a graduate school	7	12.3
9.	Improved intro. to program.	1	1.8
10.	Keep down cost	2	3.5
11.	Small load on advisors	1	1.8
12.	Student-at-a-distance program needs to be strengthened	4	7.0
13.	Staff needs more consistency	1	1.8
14.	Hire minority advisors	1	1.8
15.	Fully explain degree review	1	1.8
		57	100.3

G. Personal Information

(43) Has UWW Helped You to Become More Self Confident?

	No. of Respondents	%
YES	59	95.2
NO	3	4.8
	62	100.0
Comments:		
1. No Comment	23	37.1
2. Can identify and pursue my goals—feel more confident, trust myself	30	48.4
3. It hasn't mattered that much	2	3.2
4. Institutionally - no; Interpersonally - yes; Interculturally - yes.	1	2.0
5. Because I have a degree	1	2.0
6. I had confidence and was success oriented before UWW helped me to obtain my goals	5	9.0
	62	100.0

(44) Has UWW Helped You to Develop and Learn Skills Useful to You In Your Everyday Life?

	No. of Respondents	%
YES	54	84.4
NO	10	15.6
	64	100.0

Comments:

1.	No Comment	28	43.7
2.	How to organize, be aware of relationships, self evaluate	28	43.7
3.	Learned skills but very little theory	2	3.1
4.	Had already attained skills I needed before UWW	2	3.1
5.	Learned to become a better student	1	1.6
6.	Learned how to deal with bureaucratic red tape	1	1.6
7.	UWW education was not skill oriented but experience oriented	1	1.6
8.	Am looking for teaching assignment in addition to work	1	1.6
		64	100.0

(45) Has UWW Helped You to Identify, Use and Relate to Learning Processes When They Are Happening to You?

	No. of Respondents	%
YES	55	94.8
NO	3	5.2
	58	100.0

Comments:

1.	No Comment	34	58.6
2.	I can help others be aware of their learning	4	6.9
3.	I have a better self-understanding	16	27.6
4.	Feel I was a self-learner already	2	3.4
5.	Feel more objective and analytical	2	3.4
		58	99.9

(46) Has UWW Helped You to Clarify Personal Goals?

	No. of Respondents	%
YES	49	80.3
NO	12	19.7
	61	100.0

(46) continued

	No. of Respondents	%
Comments:		
1. No Comment	28	45.9
2. My goals are more realistic	25	41.0
3. My goals change so often it's hard to pinpoint one thing	3	4.9
4. My goals did not change while in the program	1	1.6
5. My goals were clear to me—just needed ways and means—UWW helped	3	4.9
6. This was a major element in my UWW experience	1	1.6
	61	99.9

(47) Has UWW Helped You to Do What You Wanted To Do?

	No. of Respondents	%
YES	51	89.5
NO	6	10.5
	57	100.0

Comments:		
1. No Comment	20	35.1
2. Am more of a person intent on learning throughout lifetime. Feel more capable, confident and understand myself better	14	24.6
3. Helped me to follow through with my career plans	11	19.3
4. Wanted to get a B.A.	10	17.5
5. It did not change my life style or vocation	2	4.0
	57	100.0

(48) Has UWW Helped You to Learn How to Identify and Make Use of Learning Resources in the Community, Your Job and Your Personal Life?

	No. of Respondents	%
YES	49	83.0
NO	10	17.0
	59	100.0

(48) continued

Comments:	No. of Respondents	%
1. No Comment	30	50.8
2. UWW Has helped me to feel more confident in using community resources	15	25.4
3. Always was aware of learning opportunities and resources	8	13.6
4. UWW is not well enough organized to identify or teach about the "quality of learning resources"	1	1.7
5. UWW especially taught me the use of resource persons	5	8.5
	59	100.0

(49) Other Comments on Your Experiences in UWW/LHC and How They Have Influenced Your Life.

	No. of Respondents	%
1. No Comment	28	43.1
2. UWW was an excellent, integral part of my life--a positive experience	30	46.2
3. Feel that the"power" of the program is no longer in the hands of the learners but with the UWW administration	2	3.1
4. Chief disappointment was the UWW transcript	1	1.5
5. Found I was able to catch up and get going and use life energy for something worthwhile. UWW helped me to direct my energies.	2	3.2
6. Sometimes my UWW degree is difficult to explain to others. Some think it is a way to buy a degree	1	1.5
7. If I had it to do all over again, I'd do it the same way only better on my part	1	1.5
	65	100.0

III. CONCLUSION

Thanks are due to all of the graduates who participated in this survey—their time and effort is appreciated.

This summarized data will assist program planners in their analysis and evaluation of the UWW program. Program planners will be able to use all or part of this information to re-think and re-structure program components.

Future research projects should be defined very specifically to meet specific program needs. It is recommended that future efforts include: surveying active and inactive UWW students; interviewing UWW Faculty advisors and staff, LHC faculty and staff, and resource persons. Perhaps future research projects could be compared with those involving traditional programs to see how the UWW program compares to other approaches to undergraduate higher education, in regard to its impact on graduates.

Elinor Greenberg, Director , University Without Walls and Other Special Programs
Charlene Byers, UWW Coordinator, Academic Programs and Research
Connie Artzer, UWW Graduate, Consultant

UNIVERSITY WITHOUT WALLS/LORETTO HEIGHTS COLLEGE
3001 South Federal Blvd., Denver, Colorado 80236
(303) 936-8441, ext. 221

Study of Graduates -- Spring 1976

Summary

The graduates of the non-traditional and innovative University Without Walls program at Loretto Heights College are a unique and varied group. The UWW program intends to serve, respond to, accommodate and encourage the individuality of each of the students. The graduates are, therefore, more diverse than an average group of graduates from an undergraduate educational institution. In addition, the graduates' responses to the UWW program provide important information on the strengths and weaknesses of the program. This is one way the UWW program at LHC can study itself and make appropriate adjustments and changes as it plans for the future.

The Study of the UWW Graduates was conducted in February, 1976. Of the total 169 graduate population, ninety-one (54%) responded.

A profile of the respondents provides basic information on the nature of the UWW program at LHC and its constituency. Only 20% of the respondents fell into the "traditional college age" group of 19-22 years at time of enrollment. Almost a third were over 40 years of age. Fifty-five percent of the respondents are female; and over 50% are married. Over 30% have three children or more, while 37% have none. Over 15% are Chicano, Black, Native American, or other ethnic minority.

The graduates' academic backgrounds are equally diverse. Most of the respondents attended one or more colleges or universities before UWW, with almost 30% attending three or more, and transfering credit from those institutions. Over three fourths of the respondents received Advanced Standing Credit for demonstrated learning acquired prior to their enrollment in UWW/LHC. Sixty percent had a lapse of more than one year between prior college and UWW, including 11% with a lapse of 15 years or more. Thirty-one percent of the respondents held professional licenses or certifications (Teacher Certification, CPA, etc.) at time of their response to the questionnaire. One third of these certifications were acquired after the completion of the UWW program and the awarding of the BA degree from LHC.

The experience of the respondents while working toward their degrees shows clearly the range of student needs present in the program. Twenty percent selected Counseling as their Area of Concentration, 15% Education, 10% the Arts, 10% Business, and the rest spread relatively evenly among such areas as Communications, Law, Religion/Philosophy, History, Culture, Research/Statistics, and others. Over half were able to complete their degrees in two semesters, while more than 10% took over four semesters. Over a third received financial aid while attending UWW and almost 90% lived in the Denver area.

Post-graduation experiences are as important as any other single criterion in evaluating the effectiveness of the UWW program. Over 40% (37) of the respondents had applied to graduate schools and, at time of response, twenty-seven (73% of the graduate school

applicants) had been accepted. Five persons had already completed their M.A. degree programs. Interestingly, when asked if they would attend a graduate school on the UWW model, were one available, over 80% responded affirmatively. The employment picture is equally important. Over 70% responded that their LHC B.A. degree had improved their job potential and 80% indicated a salary increase since degree completion. At time of response, almost a quarter of the respondents earned $15,000 or more per year.

The graduates' evaluations of the UWW program and it's processes are among the most useful types of feedback for the program. In all but a few cases, at least 90% or more of the graduates rated the specific UWW processes "satisfactory" or "excellent." The procedures, through which virtually all the students pass, include: admissions, registration, degree planning, advisement, staff support, learning contracts, learning resources, advanced standing, learning segment evaluations, transcripting, and degree review. Those items which were not rated quite as highly as the UWW program processes include LHC Financial Aid, LHC courses, and LHC support services. The LHC financial aid process was rated satisfactory or excellent by 77% of the respondents who used it. Loretto Heights courses were rated satisfactory or better by 87% of those who included them in their learning program, although only 55% of the respondents used them. Loretto Heights' support services were rated satisfactory or excellent by 83% of the respondents.

The perceptions of the graduates about the program further describe the nature of the UWW/LHC enterprise. Almost sixty percent see the major strength of the program as "support, flexibility, humor--lots of self growth." Another 24% see the staff and advisors as the major strength. There was no such consensus on the weaknesses of the program. The largest agreement existed among the almost 15% who saw the program as "disorganized" or "unclear." Other weaknesses, supported by from 4 to 10% of the respondents, included lack of community/student involvement, bureaucracy, lack of support from advisors, the need for more contact with a traditional program, and the high cost of tuition. Issues of concern for the respondents were the need for total credibility and the need for more direction for students. In recommending for the future, the respondents most often mentioned the need to keep the program small and minimally structured and the need for a graduate school on the UWW model.

In responding to questions on the personal impact of UWW on their lives, 95% of the respondents indicated increased self-confidence as a result of UWW. Eighty-five percent felt UWW helped them to learn useful skills, and 94% indicated that UWW helped them to identify, use and relate to learning processes when they are happening to them. Eighty percent were helped to identify personal goals, and 90% of the respondents said that UWW helped them to do what they wanted to do.

In sum, while UWW/LHC has been itself growing and developing since its establishment in 1971, it has also implemented the original Eight Organizing Concepts of University Without Walls, as articulated by the Union for Experimenting Colleges and Universities in 1971-72. These concepts, seen as goals and guidelines for UWW at LHC, include: 1) the inclusion of a broad range of persons with a diversity of age, ethnic, and economic backgrounds; 2) student involvement in the design and operation of the program; 3) help for students to achieve self-directed study, independence and confidence in setting and pursuing their own educational goals; 4) development of programs designed for and by each individual student without fixed curriculum or time schedule; 5) use of a broad array of resources for teaching and learning; 6) use of Resource Persons from government, business, community agencies, etc.; 7) access to other educational institutions; 8) development of new evaluation and assessment procedures.

According to the graduates who participated in the survey, these goals clearly have been reached for individuals. Therefore, it can be concluded that the goals have been reached for the program.

Difficulties will always arise for a new, changing, and growing program. However, the diverse and non-traditional graduates of UWW/LHC have indicated that the program has enriched their lives and expanded their worlds. The graduates' assessment and testimony strongly affirm that the assumptions, philosophies, and processes of UWW/LHC have been accurate, effective, and successful and have appropriately met the needs of a variety of learners in innovative and non-traditional ways. This may, indeed, by the best and most important indicator that UWW at LHC is on the right track in providing quality higher education for a broad range of persons. The challenge ahead is to continue to improve the program, remain experimental, flexible and innovative in approach, and increase the program's capability to meet the needs of new learners in a continually changing and complex society.

UNIVERSITY WITHOUT WALLS

February 20, 1976

Dear UWW/LHC Graduate:

The UWW, along with all other programs at Loretto Heights College, is currently involved in a self-study. This study is necessary to prepare our report for the North Central Association for Secondary Schools and College's accreditation review of the college that will be taking place in 1976-77. We are, as always, also interested in studying ourselves in order to assess our program and make efforts to improve it.

An important part of the total study of UWW/LHC is a survey of the more than 170 graduates. We would like to know what you are doing now, how you feel about your learning experiences with the UWW program, and what effect your participation in UWW has had on your life.

We have compiled a questionnaire that we hope you will complete and return to us promptly. With your cooperation, this questionnaire will give us concrete information with which to evaluate our program, share with others, and make improvements in the future.

We are aware that LHC has recently surveyed its alumnae. The enclosed questionnaire relates more specifically to you and your experiences within the UWW program. We hope you will not mind being "surveyed" twice this year.

Your response is very important to us. We would like to have you return the questionnaire by March 5, 1976. If you have any questions, please feel free to call. If you would like a copy of the results of this study, please contact us.

Please return the questionnaire to University Without Walls, c/o Connie Artzer, Loretto Heights College, 3001 So. Federal Blvd., Denver, Co. 80236.

Thank you for your cooperation.

All LHC alumnae are entitled to enroll for one 3-4 hour credit course per semester for a fee of only $25.00. Quite a savings considering tuition is $88/credit hour! We welcome you back to the college and look forward to seeing you soon.

Sincerely,

Connie Artzer Ellie Greenberg

Connie Artzer, UWW/LHC Graduate, Consultant,
Ellie Greenberg, Director, UWW & Other
Special Programs and all the UWW/LHC staff.

SURVEY OF UNIVERSITY WITHOUT WALLS/LORETTO HEIGHTS COLLEGE GRADUATES
(1971 to December 31, 1975)

SECTION I: BASIC DEMOGRAPHIC INFORMATION

1. _____
Last First Maiden/Middle

2. _____
Mailing Address

_____
Zip

3. _____
Telephone (Home) (Work)

4. _____ 5. _____
Date of Graduation (Month & Year) Area of Concentration

6. _____ Before graduation_____ After_____
Professional Certification

7. _____ 8. Were you living in Denver area?_____
No. of semesters in UWW/LHC yes/no

9. Did you receive financial aid from LHC? Yes_____ No_____
If yes,
From Loretto Heights grant_____(amount) scholarship_____(amount) loan_____(amount)
From sources other than LHC grant_____(amount) scholarship_____(amount)
Do you recall the amounts?_____(estimate)

10. Did you receive Advanced Standing Credit? Yes_____ No_____

_____
How many credits? What content areas?

11. How many colleges/universities did you attend before UWW?_____

Names & dates?_____

_____

12. Time period between prior college and UWW?_____

13. Age at time of enrollment_____ 14. Age at time of graduation_____

15. Date of Birth_____ 16. Male_____ Female_____
Month Year

17. Marital Status_____ _____ _____ _____ 18. No. of children_____
single married divorced widowed

19. _____ 20. Ethnic group _____ _____ _____ _____ _____
Age range of children Anglo Chicano Black Native American Other

Survey of UWW/LHC Graduates
Page 2

SECTION II: GRADUATE SCHOOL INFORMATION

21. Have you applied to graduate school?_____ Do you plan to in the future?_____
yes/no yes/no
If not, go on to Question No. 25.

22. If so, give name(s) of school(s) to which you've applied, title of specific graduate program(s), and degree sought; and any scholarships, fellowships, honors, etc.

Institution	Program (field)	Degree Sought	Scholarships, Fellowships, etc.

23. Have you been accepted to graduate school?_____
yes/no
If yes, list name(s) of school(s), title of specific graduate program, and degree sought, and any scholarships, fellowships, honors, etc., which you were awarded.

Institution	Program (field)	Degree Sought	Scholarships, Fellowships, etc.

24. If you have completed graduate studies:

(a) What degree did you receive?_____

(b) Institution_____

(c) Area of Study_____

(d) Honors, fellowships, etc._____

(e) Do you plan to seek additional degrees? Yes_____ No_____

Level	Field	Institution

25. If you had an opportunity to attend graduate school (MA, Ph.D., other), on a UWW model, would you be interested? Yes_____ No_____ In what field?_____
Comment:

_____

_____

Survey of UWW/LHC Graduates
Page 3

SECTION III: EMPLOYMENT INFORMATION

26. Were you employed when you entered UWW? Yes_____ No_____

If so, _____
Where Occupation Salary

27. Are you now employed? Yes_____ No_____

If you have never been employed, go to Section IV, Question 34.

If you have been employed in the past and are not now, please explain.

_____

_____

28. What is your present occupation? _____
Title Employer

29. Have you changed employers since first enrolling in UWW? Yes_____ No_____

30. Do you consider this change an improvement or promotion from your previous job? Yes_____ No_____

31. Was your participation and/or BA through UWW/LHC in any way instrumental in improving your job potential? Yes_____ No_____
Comment:

_____

_____

32. Since you first enrolled in UWW, has your salary increased? Yes_____ No_____
By how much? $1-2,000_____ $2-3,000_____ $3-4,000_____ $5,000+_____

33. Would you be willing to tell us your present salary? Yes_____ No_____
$1,000-$4,000_____ $5,000-$10,000_____ $10,000-$15,000_____
$15,000-$20,000_____ $20,000+_____

SECTION IV: COMMUNITY INVOLVEMENT INFORMATION

34. Are you engaged in any community activities or organizations? Yes_____ No_____

Name of Organization	Type or Purpose of Organization	Nature of Your Involvement

35. (a) Have you received any special awards, certificates, publications, commendations, honors, etc., since graduating from UWW? Please list.

_____

_____

_____

(b) Were your learning experiences at UWW in any way instrumental in your receiving these awards/commendations? Yes_____ No_____

36. May we have permission to publish this information in UWW publications, research, reports and the like? Yes_____ No_____

You may use my name_____ Please keep me anonymous_____.

SECTION V: ALUMNAE INVOLVEMENT

37. Are you interested in maintaining your involvement with UWW/LHC?

Yes_____ No_____

In what way? Receiving a newsletter?_____Involvement with a committee?_____

Being a resource person?_____ Other_____

38. Are you interested in giving financial support for scholarships for UWW students?

Yes_____ No_____ For other UWW projects or activities? Explain.

_____

_____

39. Do you wish a copy of the results of this graduate study? Yes_____ No_____

SURVEY OF UNIVERSITY WITHOUT WALLS/LORETTO HEIGHTS COLLEGE GRADUATES
(1971 to December 31, 1975)

SECTION VI: EVALUATION OF UWW AT LHC
(Please use additional sheets for comments, if necessary.)

40. How did you hear about the University Without Walls?_____

_____

41. Please rate and comment upon the following University Without Walls/Loretto Heights College processes:

	Unsatisfactory	Satisfactory	Excellent
Admissions: Comments:	_____	_____	_____
Financial Aid: Comments:	_____	_____	_____
Registration: Comments:	_____	_____	_____
Degree Planning: Comments:	_____	_____	_____
Advisement: Comments:	_____	_____	_____
Other UWW Staff Support (Director, Coordinators, Secretaries, etc.) Comments:	_____	_____	_____
Learning Contracts: Comments:	_____	_____	_____
Resource Persons & Learning Resources: Comments:	_____	_____	_____
Loretto Heights College courses: Comments:	_____	_____	_____
Advanced Standing Credit Proposals & Evaluation:	_____	_____	_____
Learning Segment Evaluation: Comments:	_____	_____	_____

Survey of UWW/LHC Graduates
Section VI, Page 2

	Unsatisfactory	Satisfactory	Excellent
Transcripts and Transcript Supplements: Comments:	_____	_____	_____
Degree Review Session: Comments:	_____	_____	_____
Loretto Heights College Support Services: Comments:	_____	_____	_____

42. Please comment on the following:

a) What expectations did you have of University Without Walls when you began the program? What did you experience?

b) What were some of the strengths of the program?

c) What were some of the weaknesses of the program?

d) Specific issues of concern for you?

e) Describe the impacts of your UWW experience on your life.

f) Recommendations for the future?

SECTION VII: PERSONAL INFORMATION

43. Would you say your experience with UWW has helped you to become a more self-confident person? Yes_____ No_____ Explain.

44. Has UWW helped you develop and learn skills useful to you in your everyday life? Yes_____ No_____ Explain.

Survey of UWW/LHC Graduates
Section VII. Page 3

45. Has UWW helped you to identify, use, and relate to learning processes when they are happening to you? Yes_____ No_____ Explain.

46. Has UWW helped you to clarify your personal goals? Yes_____ No_____ Explain.

47. Has UWW helped you to do what you have wanted to do? Yes_____ No_____ Explain.

48. Has UWW helped you to learn how to identify and make use of learning resources in the community, your job and your personal life? Yes_____ No_____ Explain.

49. Any other comments on your experiences in UWW/LHC and how they have influenced your life:

CA: 2/20/76

APPENDIX B

COLLEGES RESPONDENTS ATTENDED BEFORE UWW/LHC

Arizona State University
Loretto Heights College
Kenyon College
Stephens College
Goddard College
University of Colorado (Boulder & Denver)
University of Southern Colorado
Colorado College
Metropolitan State College
Denver University
Colorado State University
Western State
Community College of Denver
Rice State University
Mt. San Antonio College
Long Island University
Suffolk University
University of Hartford
Dean Junior College
University of Maryland
University of Madrid
University of Nebraska
University of Omaha
United States Air Force Academy
Bryn Mawr College
Chapman College
Nathaniel Hawthorne College
Farleigh Dickenson University
College of William and Mary
Marquette University
Cameron College
Brandeis University
Fayetteville State College
Long Beach City College
Northeastern Junior College
Indiana University
University of Minnesota
Utah State University
University of Georgia
University of Texas
Creighton University
Mesa Junior College
College of Santa Fe
N. Texas State University
University of San Francisco

APPENDIX C

GRADUATE SCHOOLS AT WHICH UWW STUDENTS WERE ACCEPTED

*University of Denver (4)**
*University of Colorado (8)
*University of Northern Colorado (4)
*Juarez Lincoln Graduate School (1)
*Goddard College (4)
Occidental College (1)
*Virginia Polytechnic Institute (1)
University of Iowa (1)
Kansas State University (1)
*E.W. Cook School (1)
*St. John's College (1)
California State University at Fullerton (1)
*California State University at Hayward (1)
*University of Utah (1)
*Iliff School of Theology (1)
*George Peabody College (1)
*St. Thomas Seminary (1)

*Schools which UWW/LHC graduates are attending.
**Number of students accepted into this graduate program.

GRADUATE DEGREES COMPLETED

University of Denver, Library Science
University of Colorado, Communications
University of Denver, Law
Occidental College, Drama
Iliff School of Theology, Theology

APPENDIX D

OCCUPATIONS OF UWW GRADUATES

Counselor (8 graduates)
Self-Employed (9 graduates)
Data Analyst
Research Assistant
Law Clerk (2 graduates)
Surgical Technician
Realtor
Teacher Corps Intern
Head Nurse
Free Lance Photographer
Food Service Administrator
Employ-Ex Director
Chief Rehabilitation Counselor
Army Staff Sargent
U.S. Government Division Administrator
College Instructor
Director—Larimer County Corrections Project
Housewife
Geriatric Nurse Practioner
Asst. Chief of Alcohol Programs at Denver General
Library Technician
Substitute Teacher
Administrative Secretary
Minister-at-Large
Pre-School Coordinator
Nurse
Caseworker, National Jewish Hospital
Instructor—Community College
Reporting Steno
Temporary Secretary
Coordinator of Volunteers—Project New Pride
Instructor—Denver Public Schools
Teacher—Montessori School
Program Director—YWCA
Salad Maker
Winterization Specialist
Insurance Underwriter
Vice President of Operations—Trust Corporation
Director of Admissions, Columbia College, Columbia, Missouri
Community Volunteers Coordinator
Graduate Assistant
Salesman
Tour Guide
Writer (3 graduates)
Director of Communications
Inter-Personal Communications Counselor
Graphic Artist
Lobbyist
Public Info. Specialist
Yoga Teacher—Metro College
Director/Teacher—New Horizons
Instructional Aide—Community College
Speaker of the House of Representatives, Colo. State Legislature
Majority Leader, House of Representatives, Colo. State Legislature

APPENDIX E

ORGANIZATIONS TO WHICH GRADUATES BELONG

Big Sisters
Denver Free School
Church
Legal Aide
Mountaineering Club
Soccer Team
Boulder Human Relations Commission
Boulder Housing Committee
Alternative Learning
American G. I. Forum
Denver Boys Club
Latin American Research Agency
Urban League
Colorado Corrections Association
Labor Group
Denver Chamber of Commerce
National Association for the Advancement of Colored People
United Latin American Citizens
Chicano Historical Society
National Bilingual Association
Governors Commission on Corrections
Masonic Lodge
Adult Education
Denver Art Museum
Goethe Club
Colorado Nursing Association
Governors Board for Mental Health
Arapahoe County Task Force
Lakewood Civic Association
Garden Club
Mother-to-Mother Program
Boulder Free School
Extension Homemakers
St. Mary's of Littleton Womens Group
Lawyers Guild
Boulder Poets Collective
Booster Club
Beyond Divorce
American Lung Association
Greater Park Hill Association
Colorado Status of Women
Spiritual Community
University of Colorado Womens Club
Botanical Gardens
Alliance France
Colorado Mountain Club
Cub Scouts
Little League
Westerners
American Association of University Women
March of Dimes
Outdoor Writers of America
Toast Masters
Mothers for Peace
Democratic Party
Colorado Social Legislation Commission
League of Women Voters
Childrens Center

APPENDIX F

AWARDS, HONORS, ETC., GRADUATES HAVE RECEIVED

- Listed in Who's Who of American Women and in Who's Who of International Women - Kay Rosenberg.
- Editor and Publisher of Colorado Womens Digest - Judy Miller.
- Awarded Whitney-Bancroft Award (received highest grade in law school) - Allan Beezeley.
- Free lance photographer for Getty Oil, Eastern, New York - George Diebold.
- Received NOAA's (National Oceanic and Atmospheric Administration) Outstanding Women's Award - Delores Belsher.
- In process of having book published about Early Childhood Education - Ardeth Dickson.
- Published booklets for Community College - Judith Harrell.
- Outstanding Achievement Award - 1975 - name withheld.
- Received a cash award ($500) for special project on Alaska Planning; Received a cash award ($250) for work on Parks, Plants and People; Published a number of news feature stories for National Parks Courier and published a story in Ski Time - Naomi Hunt.
- Published a chapter of a book on Family Crisis and currently involved with a venture concerning sharks teeth in South America - Lawrence Fish.
- Author of published booklet on Family Day Care - Connie Artzer.
- Presidential citation for corrections work - name withheld.
- Army Good Conduct Medal - Billy Rhodes.
- Has written a script for a one hour T.V. special; Guest speaker on Channel 2 & 7 discussing the elderly; Editor and Announcer of Historic LaRaza - KLZ-FM - Lamberto Armijo.
- Write up in Denver Post and Rocky Mountain News concerning her career in Gerontology - Erika Saak.
- Published article, "Community Support Systems for Chronic Patients" - B. J. Smith.
- Honored statewide by Homemakers Extension Club as member to accomplish goals in past 10 years - R. O'Connor.
- Nominated to Union for Experimenting Colleges and Universities Board - Pat Madsen.
- Working on two publications as co-author - name withheld.
- Appointed Chaplain by U. S. Government - Mary Brinkhopf.
- Going on Nursing Study Tour of Russia, Finland, Poland - Martha Baker.
- Special Achievement Award - name withheld.
- Author of a chapter of a book - Tom Kowal.
- Author of published book on military posts in Colorado - Don Brandes.
- Editor of Student Newspaper at Iliff Seminary - James Harris.
- Submitted a training article for publication - Perry Van Dixon.

APPENDIX G

LIST OF CERTIFICATIONS RECEIVED BY UWW/LHC GRADUATES

A. Certification received before entering UWW/LHC

- Counseling Certification
- Registered Nurse (9)
- Real Estate License (2)
- Day Care Director Certification
- Psychological Technician
- Teacher Certification
- Ordination to the Ministry
- Geological Certification
- CPCU; Insurance Underwriter
- Welding Certification (North Carolina)

B. Certification received after completing UWW/LHC

- Day Care Director Certification
- Teacher Certification
- Psycho-dramatist Certification
- Food Administrator Certification
- Certified Public Accountant (CPA)
- Ordination to the Ministry
- Deacon Orders (of the Ministry)
- Bar Exam Passed
- Vocation Credentials (Colorado)
- Government Reporting Stenographer Certification

UNIVERSITY
WITHOUT
WALLS

A study of UWW graduates was conducted in February, 1976. Of the total 169 graduate population at that time, ninety-one (54%) responded. Over 40% (37) of the respondents had applied to graduate schools and, at time of response, twenty-seven (73% of the graduate school applicants) had been accepted. Five persons had already completed their M.A. degree programs. Over 70% responded that their LHC B.A. degree had improved their job potential and 80% indicated a salary increase since degree completion. At time of response, almost a quarter of the respondents earned $15,000 or more per year.

an independent,
coeducational,
liberal arts college

Pam Davis

July 28, 1977

3001 South Federal Boulevard
Denver Colorado 80236
303 936-8441

UNIVERSITY

WITHOUT

WALLS

Age range of students currently enrolled in UWW: 18 - 65

Average age: 35

Age breakdown of the approximately 117 students currently enrolled in the University Without Walls Program:

Age	% of Students
18 - 22	9
23 -29	34
30 - 39	30
40 - 49	15
50 - 65	12
	100%

an independent,
coeducational,
liberal arts college

Pam Davis

July 28, 1977

3001 South Federal Boulevard
Denver Colorado 80235
303 936-8441

The college catalog for Loretto Heights College in Denver, Colorado is on file at the U.S. Commission on Civil Rights.

the heights

3001 South Federal Boulevard
Denver, Colorado 80236
(303) 936-8441
Admissions

Dear Prospective UWW Student:

We are pleased to learn of your interest in the University Without Walls (UWW) Program at Loretto Heights College (LHC).

The UWW at LHC began in 1971 and has graduated more than 250 persons with Bachelor of Arts (B.A.) degrees from Loretto Heights College in individually designed Areas of Concentration, such as business administration, management, fine arts, human services, and many others. More than 100 students are enrolled in UWW/LHC each semester. These diverse men and women, ranging in age from 16 to 74, come from a wide variety of backgrounds and experiences.

As a UWW student, you will be aided in planning your individually-tailored curriculum, based on your particular life experiences and future goals. UWW students may take advantage of the vast array of learning resources available in the community - combining courses at many colleges, employment, volunteer service, creative projects, independent study, travel, workshops, in-service training and other activities.

Each UWW student works on a one-to-one basis with a UWW Faculty Advisor and with the student's own team of Resource Persons. The UWW student combines theory and practice, both on and off campus, while seeking to develop knowledge, skills, and competencies appropriate for our fast-changing society. Advanced Standing academic credit may be proposed for prior learning and competencies gained in non-college environments. Since the average age of UWW students is 35, the program provides opportunities for mature adults to demonstrate the learning they have gained through prior non-college life experience. UWW stresses self-directed learning, independence, and creativity; and focuses on each individual's needs in a context of collaboration with the program.

We are sending you UWW and LHC information and applications. Applications are accepted at any time and enrollment occurs monthly (with the exception of August, December, and May), dependent on space available in the Program. Pre-Admissions Workshops are held weekly to answer your questions. If you need a financial aid application, please contact the Financial Aid Office at LHC. If you have further questions, please do not hesitate to call the UWW Admissions Coordinator.

We recognize that UWW is not for everyone, but we hope that it might be just what you have been looking for. We look forward to getting to know you soon and to having you join us in one of the most dynamic and flexible innovative college programs in the country - The University Without Walls at Loretto Heights College.

Sincerely,

Ellie Greenberg

Ellie Greenberg, Director
University Without Walls
and Other Special Programs

The Academic Process

UWW student Evelyn Duncan and faculty advisor Mike McCarthy

Registration

Enrollment and registration of new students occur throughout the year at the beginning of each month except May, August, and December.

Orientation

On the afternoon of the initial enrollment in the program new students attend an orientation in order to meet the staff and each other, receive answers to their questions, and to receive an orientation to the campus and the program.

UWW Processes Workshops

After each enrollment, UWW faculty and staff conduct a workshop, "Introduction to UWW Processes", to introduce new students to the UWW vocabulary; policies; procedures; and processes, including writing learning contracts, finding learning resources, evaluating nontraditional learning, applying for learning stipends, transcripting credit, etc. In addition, the faculty and staff offer special workshops on the Advanced Standing Credit Evaluation process and the Degree Review process.

Advanced Standing Credit Evaluation

If students wish to propose to receive academic credit for learning acquired outside the traditional college classroom, they may do so through the Advanced Standing Credit Evaluation process. After entering the program, the student prepares a proposal documenting past learning experiences and demonstrating the scope and depth of the prior learning. Advanced Standing Learning Credit Evaluation guidelines are available upon request to assist students in the preparation of these proposals. The UWW advisor and the Coordinator of Academic Programs and Research also support and assist the student in this process. The student convenes an Advanced Standing Credit Evaluation Committee to evaluate the proposal and to approve or revise the proposed number of credits.

Area of Concentration

A UWW student, in collaboration with the faculty advisor, designs and identifies an individualized area of concentration (similar to a major). The student must complete at least thirty credit hours in this area. Students have graduated with a variety of areas of concentration and many have designed cross-disciplinary areas of concentration. A student may have two areas of concentration and must complete a minimum of thirty credit hours in each.

Learning Contract

At the beginning of each sixteen week learning segment (semester) the student meets with the faculty advisor and resource persons to establish learning goals for the term. Together they decide how to achieve the stated goals and how to evaluate learning at the end of the learning segment. The end result of these decisions is a learning contract which specifies each aspect of the semester's learning within the total degree plan. All persons involved in each learning experience sign the contract to indicate their agreement.

Learning Resources and Resource Persons

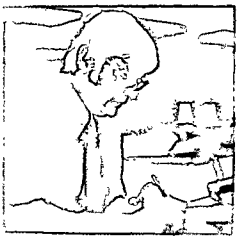
During a student's program s/he will work and study with a variety of persons skilled in his/her areas of interest. Students will also attend classes, workshops, seminars, and conferences and may include internships, in-service training, travel, and other learning experiences as part of their degree plan. Although students often identify these resources for themselves in consultation with the advisor, the services of the coordinator of learning resources are available. The coordinator helps individuals locate persons and other learning resources necessary for the completion of a balanced degree program. The monthly UWW newsletter includes not only news of the program but also lists available learning resources including people, places, things, and events.

The Learning Stipend

An enrolled student may apply for a learning stipend after completing a learning contract. The stipend is a limited portion of paid tuition to be used to help cover the expenses of off-campus learning, including tuition for courses on other campuses, fees for workshops, and reimbursement of resource persons.

Evaluation for Granting Academic Credit and Grading

The instructor evaluates a student's learning resulting from courses taken at LHC or at other colleges in the established manner. The student, advisor, and resource persons determine evaluation methods and criteria for other UWW learning and specify these in the learning contract. Students indicate in the contract whether they will propose to receive a letter grade or a pass/fail designation. Faculty hold evaluation sessions at the conclusion of each learning segment/semester; methods of evaluation take a variety of forms – discussions, projects or other demonstrations of skills, papers, tests, or other procedures that demonstrate learning. The resource persons, selected for their particular areas of expertise, help to evaluate students' knowledge and performance competencies, and students also evaluate themselves. The faculty advisor is responsible for granting academic credit. The student and faculty advisor prepare transcript supplements detailing each learning experience and its results. The supplements are attached to the LHC Permanent Record (transcript). The registrar secures these documents in a permanent file.



UWW business graduate Chuck Sponburgh

Degree Requirements

To graduate from LHC through UWW, the student must earn 128 passing semester credits. A candidate for graduation must earn the final consecutive thirty credits as an actively enrolled UWW/LHC student. The student anticipating graduation must demonstrate in-depth learning in an area of concentration and the breadth of knowledge appropriate to a liberal arts graduate. Also, a student must demonstrate competence in the following areas: communication skills, goal setting, self-evaluation, initiative, creativity, personal growth, service to others, and life-long learning skills.

JUST WHAT IS AN EDUCATED PERSON, ANYWAY?

"University Without Walls at Loretto Heights College has set out to free persons to be what they wish to become, on their own terms, in their own ways – it is an honest, logical, open approach to true learning, recognizing the fact of credentials, creatively seeking to adapt institutional habits to serve individuals' needs.

In the University Without Walls we seek to be leaders, aiding individuals to free themselves. We seek relationships, knowledge, integrity, and joy.

We are unique because the persons who participate in University Without Walls are unique – whatever we accomplish is due to this single fact."

Elinor Greenberg
Director, University Without Walls and
Other Special Programs

Applying For Admission To The Program

UWW/Teacher Corps student Andy Garcia working with Westside Youth Development students

Pre-Admissions Workshops

The UWW coordinator of admissions conducts weekly workshops on campus to explain the program to interested persons and to answer their questions. Call the Loretto Heights Admissions Office (936-8441, ext. 216) for details. A potential applicant can also request a personal appointment with the admissions coordinator.

Application

To apply to the UWW program, a person must submit a regular LHC application, including transcripts, test scores, and letters of recommendation, and a supplementary UWW application. An applicant to UWW must also submit a tentative degree plan as described in the supplementary UWW application form. The UWW admissions committee reviews all applications and considers them in terms of the applicant's potential to learn independently and the program's ability to serve the applicant's needs. The committee gives special consideration to the issues of distance, cost, resource expectations, and professional licensing standards and will often ask applicants to come to the college for an interview.

The criteria used by the UWW admissions committee differ from those of more traditional programs. UWW seeks evidence of:

1. A desire to learn
2. A need to explore alternative approaches to learning
3. A capacity for working independently and in groups
4. Motivation, creativity, and interest in setting goals for oneself

Active Full-Time Status

A full-time student is one who has been accepted into the program and who has registered and paid for eleven to eighteen semester credit hours. A student must pay for additional credit hours at the per credit hour rate and must receive special permission to register for additional hours.

Active Part-Time Status

A part-time student is one who has been accepted into the program and who has registered and paid for less than eleven but more than six credits. A part-time student may become a full-time student at the beginning of his/her next learning segment.

Conditional Acceptance

UWW may admit on conditional acceptance those students whose records and applications leave some doubt about their ability to succeed in the program. The admissions coordinator and the UWW staff will discuss the conditions of acceptance with the student. In most cases, it is up to the student during the first learning segment (semester) to demonstrate that the UWW program meets his/her needs, goals, and capabilities. The evaluation at the end of the first learning segment determines if the student has met the conditions of the acceptance.

Special Students

A special student is one who has been accepted, has registered and has paid for less than six credit hours, and is not, at the time, a matriculating degree candidate. Special student application forms are available in the admissions office. The special student applicant need not submit transcripts or pay an application fee. If a special student decides to become a degree candidate, however, the regular admissions process must be completed.

Students-at-a-Distance

Persons who live outside the Denver-Boulder area but who live in the Rocky Mountain region or in the states bordering on Colorado are considered Students-at-a-Distance. UWW expects them to be on campus for registration, orientation, and the "Introduction to UWW Processes" workshop. In most cases they will register as full-time degree candidates. Students-at-a-Distance must make special arrangements for part-time or special student status prior to acceptance. Students located in the same area may form clusters and meet as a UWW learning community. A cluster of UWW students is developed in the Glenwood, Aspen, Roaring Fork area of Colorado. Other locations are currently in the development stage. All Student-at-a-Distance applicants should request the guidelines explaining this aspect of the program. All arrangements and expectations between these students and the program should be clear prior to admission and enrollment.

Teacher Education in UWW

Persons interested in acquiring Colorado Teacher Certification from the Colorado Department of Education in elementary, secondary, or special education may apply to the UWW/Competency-Based Teacher Education Project (CBTE). Persons may be degree and certification candidates or certification candidates only. Special information and applications are available upon request from the admissions coordinator.

Deadline for Active Enrollment after Admissions

Students accepted to the UWW program must enroll within a year of the date of acceptance. A student who does not enroll within that time must reapply for admission to the program.

Important Details

LHC faculty member Sr. Damian Mary Simmons with UWW/CBTE student Betty Schiller

Tuition Costs

Loretto Heights College is an independent institution. It is not publicly supported through the state government. Tuition is $1,475.00 per learning segment (sixteen week semester) for a full-time student. Part-time student tuition is $95.00 per semester credit hour (1976-77 rates, subject to change.) (See "The Learning Stipend" section under Academic Process.)

Financial Aid

UWW applicants and students apply for financial aid through the LHC Financial Aid Office. The types of aid available are: direct grants, student loans, and/or work study grants. The deadline for all financial aid applications is March 1 for the following academic year (July 1-June 30). Applications received after March 1 are considered on a "first-come, first-served" basis. Check with the financial aid office (936-8441, ext. 274) for financial aid forms and further information. A large percentage of UWW students apply for and receive financial aid.

College Services to Students

As Loretto Heights students, UWW students are entitled to all college services including:

- —Full use of the LHC library including audio-visual material and equipment;
- —The services of the student services office, including testing and counseling for interests and aptitudes;
- —Health services;
- —Use of the swimming pool;
- —Student reductions at college events (theatre, concerts, lectures, etc.);
- —Student bus rates;
- —An LHC student ID card entitling the holder to student discounts;
- —Use of the Resource Center on Women and Center for Religious Meaning;
- —Use of dining facilities on campus (student may purchase semester meal ticket or individual meals).

Students can obtain information about on-campus housing from the admissions office or the office of student services.

LHC Academic Policies, UWW Handbook, and UWW Guidelines

Detailed information about LHC and UWW academic policies and procedures is available to students at registration. The LHC Academic Policies, the UWW Handbook, and a variety of UWW guidelines specify the policies and procedures of the program and the college. The college expects all students to have copies of these publications and to be familiar with all LHC and UWW policies and guidelines.

PROJECT TRANSITION . . . bringing learning to life

Project Transition is an individualized educational approach which is designed to encourage new learning about adulthood and to promote effective career/life planning. The project is particularly recommended for persons who are exploring new options or directions - in their work, in personal relationships, or in other important areas of their lives.

The total project lasts four months and requires about five hours each week in seminars and consultation. Additional time will be spent outside the seminar sessions on readings. Participants in the project can earn six semester hours of undergraduate credit from Loretto Heights College. Students may also begin to develop proposals for additional academic credit, based on demonstrated learning gained in prior non-college experiences. Evaluation and credit granting for this "advanced standing credit" occurs only after full application, acceptance and enrollment in the UWW program as a degree candidate.

Project Transition has two parts: a series of four one-month seminars, and an individualized career planning program. The seminars are designed to provide a supportive small group atmosphere for studying issues of personal and professional importance. They are intended also to help persons make informed choices about further higher education.

Each of the seminars has been developed around subjects important to adult life in 20th century America. The subjects include:

- The Psychology of Adulthood - introducing a variety of models for understanding the human life cycle from young adulthood through the aging process, and examining recent studies of important transitions of adulthood;
- Values in Adult Experience - exploring alternative systems of values, their philosophical and ethical roots, and processes by which values can be clarified so as to support responsible action;
- Perspectives on the Future - probing new methods of projecting and preparing for emerging social and political trends, examining studies of the "limits to growth" and issues of resource allocation, and the implications of technology for our future society;
- Learning as Adults - assessing, on the basis of experiences in the three previous seminars, each individual's most comfortable and productive learning style, and exploring through reflection and reading, the particular dynamics and challenges of self-initiated learning.

The career planning process will utilize a variety of resources, including methods which emphasize individual values and interests, career awareness, and career development skills. Through the entire, comprehensive process, each person will be helped to clarify career directions and to identify appropriate educational resources and other paths to a satisfying life.

Project Transition will be conducted on the Loretto Heights College campus. Also, on the basis of interest, Project Transition can be arranged for groups of persons and located at the workplace. For further information, please contact Dr. William Charland or Pam Davis, University Without Walls, Loretto Heights College, 3001 South Federal Boulevard, Denver, Colorado 80236; (303) 936-8441, Ext. 221, 222.

7/77

PROJECT TRANSITION

Fall, 1977 - September through December

A Project for Adults

to learn and share new insights into adult experience

to explore and clarify important personal goals, interests and values

to gather resources and plan for a satisfying future

to earn academic credit and experience new learning styles

through the UNIVERSITY WITHOUT WALLS at LORETTO HEIGHTS COLLEGE
3001 South Federal Boulevard, Denver, Colorado 80236
(303) 936-8441, Ext. 221, 222

Changingness, a reliance on process rather than upon static knowledge, is the only thing that makes any sense as a goal for education in the modern world.
Carl Rogers, Freedom To Learn

UNIVERSITY WITHOUT WALLS/LORETTO HEIGHTS COLLEGE
3001 South Federal Blvd., Denver, Colorado 80236
(303) 936-8441, ext. 221

Study of Graduates--Spring 1976

Summary

The graduates of the non-traditional and innovative University Without Walls program at Loretto Heights College are a unique and varied group. The UWW program intends to serve, respond to, accomodate and encourage the individuality of each of the students. The graduates are, therefore, more diverse than an average group of graduates from an undergraduate educational institution. In addition, the graduates' responses to the UWW program provide important information on the strengths and weaknesses of the program. This is one way the UWW program at LHC can study itself and make appropriate adjustments and changes as it plans for the future.

The Study of the UWW Graduates was conducted in February, 1976. Of the total 169 graduate population, ninety-one (54%) responded.

A profile of the respondents provides basic information on the nature of the UWW program at LHC and its constituency. Only 20% of the respondents fell into the "traditional college age" group of 19-22 years at time of enrollment. Almost a third were over 40 years of age. Fifty-five percent of the respondents are female; and over 50% are married. Over 30% have three children or more, while 37% have none. Over 15% are Chicano, Black, Native American, or other ethnic minority.

The graduates' academic backgrounds are equally diverse. Most of the respondents attended one or more colleges or universities before UWW, with almost 30% attending three or more, and transfering credit from those institutions. Over three fourths of the respondents received Advanced Standing Credit for demonstrated learning acquired prior to their enrollment in UWW/LHC. Sixty percent had a lapse of more than one year between prior college and UWW, including 11% with a lapse of 15 years or more. Thirty-one percent of the respondents held professional licenses or certifications (Teacher Certification, CPA, etc.) at time of their response to the questionnaire. One third of these certifications were acquired after the completion of the UWW program and the awarding of the BA degree from LHC.

The experience of the respondents while working toward their degrees shows clearly the range of student needs present in the program. Twenty percent selected Counseling as their Area of Concentration, 15% Education, 10% the Arts, 10% Business, and the rest spread relatively evenly among such areas as Communications, Law, Religion/Philosophy, History, Culture, Research/Statistics, and others. Over half were able to complete their degrees in two semesters, while more than 10% took over four semesters. Over a third received financial aid while attending UWW and almost 90% lived in the Denver area.

Post-graduation experiences are as important as any other single criterion in evaluating the effectiveness of the UWW program. Over 40% (37) of the respondents had applied to graduate schools and, at time of response, twenty-seven (73% of the graduate school applicants) had been accepted. Five persons had already completed their M.A. degree programs. Interestingly, when asked if they would attend a graduate school on the UWW model, were one available, over 80% responded affirmatively. The employment picture is equally important. Over 70% responded that their LHC B.A. degree had improved their job potential and 80% indicated a salary increase since degree completion. At time of response, almost a quarter of the respondents earned $15,000 or more per year.

The graduates' evaluations of the UWW program and its processes are among the most useful types of feedback for the program. In all but a few cases, at least 90% or more of the graduates rated the specific UWW processes "satisfactory" or "excellent". The procedures, through which virtually all the students pass, include: admissions, registration, degree planning, advisement, staff support, learning contracts, learning resources, advanced standing, learning segment evaluations, transcripting, and degree review. Those items which were not rated quite as highly as the UWW program processes include LHC Financial Aid, LHC courses, and LHC support services. The LHC financial aid process was rated satisfactory or excellent by 77% of the respondents who used it. Loretto Heights courses were rated satisfactory or better by 87% of those who included them in their learning program, although only 55% of the respondents used them. Loretto Heights' support services were rated satisfactory or excellent by 83% of the respondents.

The perceptions of the graduates about the program further describe the nature of the UWW/LHC enterprise. Almost sixty percent see the major strength of the program as "support, flexibility, humor--lots of self-growth." Another 24% see the staff and advisors as the major strength. There was no consensus on the weaknesses of the program. The largest agreement existed among the almost 15% who saw the program as "disorganized" or "unclear." Other weaknesses, supported by from 4 to 10% of the respondents, included lack of community/student involvement, bureaucracy, lack of support from advisors, the need for more contact with a traditional program, and the high cost of tuition. Issues of concern for the respondents were the need for total credibility and the need for more direction for students. In recommending for the future, the respondents most often mentioned the need to keep the program small and minimally structured and the need for a graduate school on the UWW model.

In responding to questions on the personal impact of UWW on their lives, 95% of the respondents indicated increased self-confidence as a result of UWW. Eighty-five percent felt UWW helped them to learn useful skills, and 94% indicated that UWW helped them to identify, use and relate to learning processes when they are happening to them. Eighty percent were helped to identify personal goals, and 90% of the respondents said that UWW helped them to do what they wanted to do.

In sum, while UWW/LHC has been itself growing and developing since its establishment in 1971, it has also implemented the original Eight Organizing Concepts of University Without Walls, as articulated by the Union for Experimenting Colleges and Universities in 1971-72. These concepts, seen as goals and guidelines for UWW at LHC, include: 1) the inclusion of a braod range of persons with a diversity of age, ethnic, and economic backgrounds; 2) student involvement in the design and operation of the program; 3) help for students to achieve self-directed study, independence and confidence in setting and pursuing their own educational goals; 4) development of programs designed for and by each individual student without fixed curriculum or time schedule; 5) use of a broad array of resources for teaching and learning; 6) use of Resource Persons from government, business, community agencies, etc.; 7) access to other educational institutions; 8) development of new evaluation and assessment procedures.

According to the graduates who participated in the survey, these goals clearly have been reached for individuals. Therefore, it can be concluded that the goals have been reached for the program.

Difficulties will always arise for a new, changing, and growing program. However, the diverse and non-traditional graduates of UWW/LHC have indicated that the program has enriched their lives and expanded their worlds. The graduates' assessment and testimony strongly affirm that the assumptions, philosophies, and processes of UWW/LHC have been accurate, effective, and successful and have appropriately met the needs of a variety of learners in innovative and non-traditional ways. This may, indeed, be the best and most important indicator that UWW at LHC is on the right track in providing quality higher education for a broad range of persons. The challenge ahead is to continue to improve the program remain experimental, flexible and innovative in approach, and increase the program's capability to meet the needs of new learners in a continually changing and complex society.

Plants Grow on Horticultural Therapist

By LOIS CRESS
Denver Post Senior Staff Writer

Even before she completed her work toward her degree in horticultural therapy last June, Kathleen Neer knew that she would be unable to find a job immediately in her specialty in Colorado.

"But I'm not discouraged," said the 28-year-old graduate of Loretto Heights College's University Without Walls, "because I think Colorado will respond to the need for further development of this kind of therapy."

Working with plants, she said, helps in areas of socialization, increased self-esteem, new skill development and physical activity, regardless of the age, health and disabilities of an individual.

"PLANTS ARE LIVING, something people can care for and watch grow, being responsible for their care, maintenance, and taking cuttings to watch another plant develop and grow."

The horticultural therapist, she said, offers versatility in project ideas and in developing therapy programs. "They know about a variety of areas of horticulture," she said.

In her intern experience, Ms. Neer recalls a young man, "shy and with few interests of his own, separate from his family." When she first visited him, he expressed an interest in making a terrarium. Then a desire for an outdoor garden developed — eventually his own flower garden, apart from his family's vegetable plot.

"He started asking questions and became responsible and conscientious about gardening," Mrs. Neer said. "He became more talkative and seemed to be more comfortable with his peers because he had something interesting to talk about.

Denver Post Photo by Ira Gay Sealy
KATHLEEN NEER
Working with plants helps people.

"WHEN I FINISHED my internship, he was looking forward to his flower gardens blossoming and making more terrariums."

Ms. Neer envisions horticultural-therapy programs in psychiatric and general hospital settings, sheltered workshops, inner-city youth programs, senior-citizen programs and programs for the physically handicapped and as part of physical rehabilitation.

She learned about inspiring programs in horticultural therapy in other parts of the country when she attended 1975 and 1976 conferences of the National Council for Therapy and Rehabilitation through Horticulture.

"We are very far behind the rest of the country in the use of horticultural therapy," she said.

IT SEEMS CONCEIVABLE that opportunities elsewhere might lure Ms. Neer. But she wants to stay in Colorado.

"I genuinely want to see extensive programs get started in Colorado, and I want to be part of that," she said. "It's another challenge."

The only Coloradan with a major in horticultural therapy as far as she knows, Ms. Neer set up a study program at the University Without Walls. That was another challenge, "the most satisfying academic challenge I've ever had," she said.

She had undergraduate liberal arts credits from the University of Missouri and an associate degree in urban horticulture from the Community College of Denver, North Campus, when she enrolled at the University Without Walls last October.

When she was finishing her studies at Community College, she knew she wanted to go on to school. "I knew I liked working with people and with plants; and decided to combine them."

She remembers telling a Community College faculty member about her idea, which she thought was new.

"I thought 'Nobody's ever done this, using plants therapeutically,' " she said. "I thought particularly of a hospital setting much as occupational therapy is used, only using plants instead of crafts. He (the faculty member) gave me information about the National Council for Therapy and Rehabilitation through Horticulture."

She attended the council's annual conference in September 1975 at Michigan State University in East Lansing.

While there she observed the horticultural therapy program at Clinton Valley Hospital, a state hospital at Pontiac, Mich. "It has extensive greenhouses, acreages for flowers and vegetable gardens, and garden clubs for clients," she said.

FOR HER SECOND semester, Ms. Neer concentrated primarily on her internship, in which she was assisted by a $300 grant from Colorado Horticulture Research, Inc. (CHRI), a nonprofit corporation that provides funds for a wide range of horticultural projects.

"I learned so much," Ms. Neer said of the intern experience.

The clients, she said, welcomed the program. "I know that they are continuing their interest, she said.

The following 17 pages contain excerpts from "Scribes" magazine, a non-profit publication funded in part by Title I. It is produced jointly by the English Department and the Office of Community Services of Metropolitan State College, Denver, Colorado.

Scribes

The Lost Road

There's a road that winds
Through the looming pines
In a wood that is far away
A road that is lost
Where the pines are tossed
In the wind from the wind-swept bay

The coppice and heath
Are a fragrant sheath
For the soft anemones
And I think of a day
When the winds were gray
And the spindrift on the sea

I see you there
With the wind-tossed hair
And I speak to the empty day
On a road that is lost
Where the pines are tossed
In the wind from the wind-swept bay

And the word I speak
Is the hope I seek
On a road that is lost and gone
For the night shall come
And the winds shall drum
To the beat of a heedless dawn

Oh, come with me
By the lonely sea
And ride on that road today
A road that is lost
At a nameless cost
And a dream that is old and gray

For love cannot be
What the world calls free
And the price that we pay is death
When the winds shall blow
And the hope shall go
With the kiss of a careless breath

So the lost, lost road
Where a magic strode
That is out of my reach today
Shall remain to me
Like a treasury
Of the soft, sweet scent of May

Where you rode in pride
Till the fading tide
Carried your kiss away
And the gentle sigh
Of a day gone by
Was there where the breezes play

So I ride alone
On a road that is gone
On a road that is lost to me
And there's nothing there
But the empty air
And a sob from the aching sea

Stuart Hamill

Acceptance

I do not ask Forever;
  I only ask Now.
Will seek no promises--
  no need of vow.
For vows can be broken;
  their price often pain.
Promises forsaken;
  bitter tears remain.
Just give what you can Today;
  I'll not ask for more.
Except--if Now grows cold,
  softly close the door.

Joy Gautier

On the Air

On Sunday, April 17 at 9 P.M., a unique, new radio program by and for senior citizens began airing on KOSI (1430 AM). The weekly half-hour series includes news, radio documentaries in the style of television's "60 Minutes," dramatic readings and discussion of listener response. The program is hosted, written and governed completely by individuals 60 years or older.

The senior citizen radio program is a cooperative effort of the Central Bank of Denver, Public Service Comapny of Colorado, Mountain Bell, the Westinghouse Electric Corporation and the organizations representing Colorado's senior community. It is produced by a public affair in cooperation with the Senior Edition newspaper.

According to Chuck McLean, president of a public affair, the program has several objectives. In addition to providing a forum for discussion of issues and opportunities confronting the over-60 community, the program seeks to demonstrate that the productivity of the individual does not diminish with retirement. McLean added the program ends each week on a positive note. "We ask honest, probing and sometimes controversial questions," he said, "yet solutions and positive action are a most important part of each program."

The senior citizen radio program is hosted by a male and a female over 60. 26 different seniors will give dramatic readings during the show's initial run. Co-hosts and dramatic readers were chosen in a series of auditions held in 10 Denver locations from March 3 - March 16. Among the more than 140 audition participants were individuals of diverse backgrounds, including a Cherokee woman sho drove oil trucks during the Oklahoma boom days; a veteran of London's Shakespearian theatre; a former Colorado secretary of state under Governor Vivian; the founder of a local radio station; a licensed mortician; a retired disc jockey; and, a lady who hosted her own radio program in the 1930s.

Input from the senior community has been requested at all stages by the program's Senior Advisory Board. This board includes representatives of the American Association of Retired Persons, Colorado Congress of Senior Organizations, Seniors, Inc., Volunteers of America, The Gray Panthers and other organizations. Those wishing to contribute should write to Joanne Carr at a public affair, 2015 So. Pontiac Way, Suite 1-b, Denver, Colo., 80224; or telephone her at 759-4475 or 779-0971.

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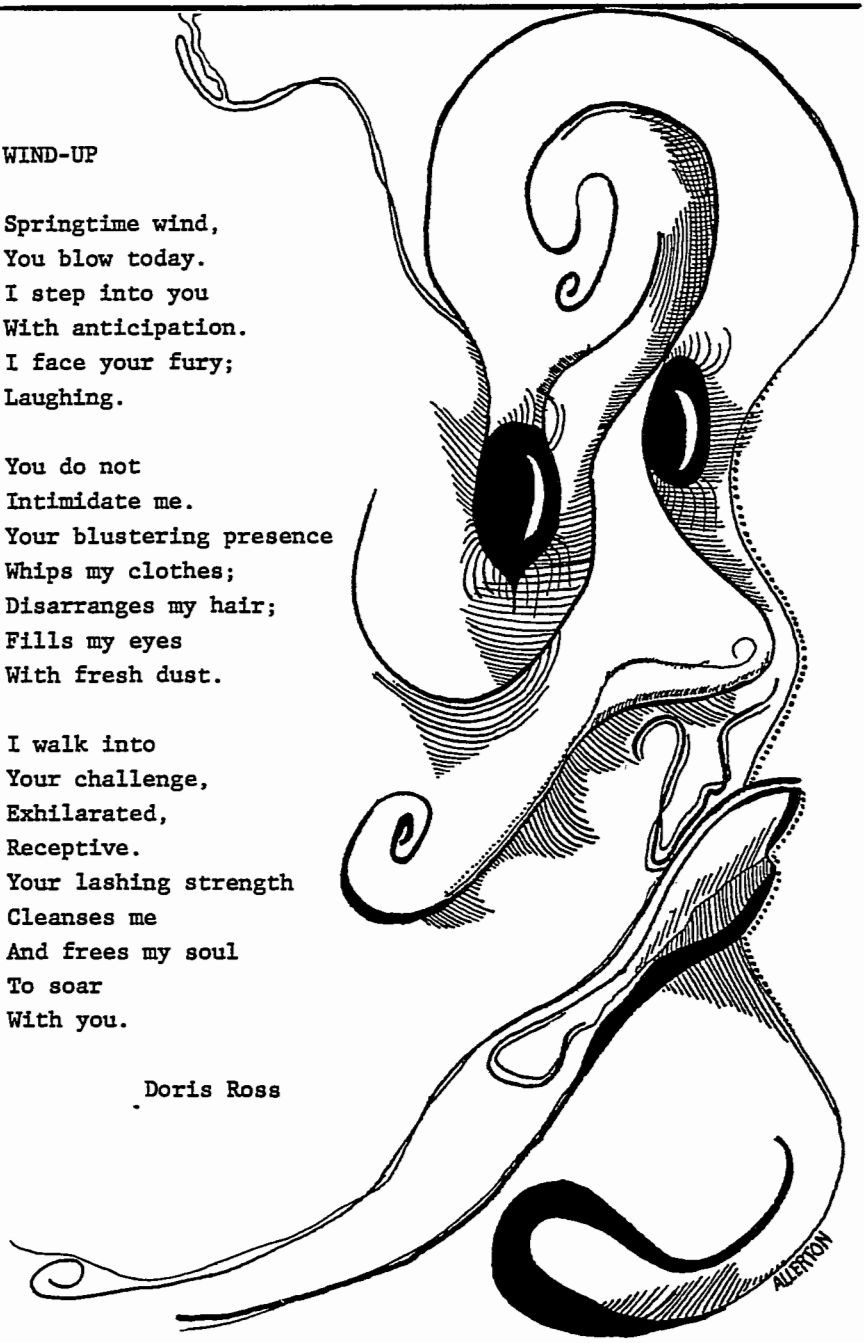

WIND-UP

Springtime wind,
You blow today.
I step into you
With anticipation.
I face your fury;
Laughing.

You do not
Intimidate me.
Your blustering presence
Whips my clothes;
Disarranges my hair;
Fills my eyes
With fresh dust.

I walk into
Your challenge,
Exhilarated,
Receptive.
Your lashing strength
Cleanses me
And frees my soul
To soar
With you.

Doris Ross

Scribes

Olietta Moore ◆◆◆

Every once in a while a woman is born who seems destined for great things. This woman might be taken as a modest, unassuming resident of her community, but beneath this outward appearance are records of accomplishment and testimonies of outstanding services and contributions to a society. Such a woman is Olietta Moore.

Ms. Moore is a native of Colorado, and has left her mark in the archives of this state, as well as in those of U.S. history. To begin with, her genealogy seems much like a chapter out of Roots. In one case, her ancestry dates back to the ninth President of the United States, William Henry Harrison. As was common in those days, many children were born to the young black women of their slavemasters. Thus her grandfather, John James Harrison was born: But unlike his predecessors, he would not be a slave.

Olietta's father was born on the "Cherokee Strip" of Oklahoma. In 1882, Walker Anderson moved to Colorado and settled on the site of what is now 6th and Tennyson Sts. Olietta's father was one of Colorado's pioneers in the mining and building industries. He owned mining claims in Silverplume, Blackhawk and Central City. One can appreciate how unusual it was for a black man of those times to not only be a landowner, but be the owner of several gold-mines as well! Walker's business in Denver was construction. He helped build the Miner's Exchange Building, Saint Anthony's Hospital, the old Courthouse Building, and Central Bank and Trust. He was a successful man whose talents were used to help rejuvenate the Central City Opera House in 1900.

Olietta's mother was Henrietta Harrison. She came to Denver in 1890 as a visitor from Alabama. Here, she later fell in love with Walker, and they were married in 1902. An ambitious woman, she worked as an employee at the Post Office on top of raising a family. She retired in 1943.

As a child, Olietta learned much about the business and industry of early Denver and Colorado. After attending Eagleton School, where incidentally all of five generations of her family have attended, she moved up to North High School, where her life-time interest in music was born and nurtured. At North High she met and eventually married Cecil Moore.

Gifted in performing and composing music in high school, Ms. Moore went on to D.U.'s "Lamont School of Music." There she wrote many musical scores, which cover the wide range...from "swing" to "classical." In her subsequent years as a musician and composer, Ms. Moore has had many of her works published and filed with the Library of Congress. Some of these include:

"I'm Just a Weary Traveler"
"Brokenhearted"
"I'm Growing Old"
"Swing is the Thing For Me"

Her classical pieces number among:

"Song Without Words"
"Espanita"
"Hungarian Dance"

In 1938 an interesting occurrence took plance. Marian Anderson was scheduled to perform at the D.A.R. convention in Washington that year. She was prevented from appearing, however, and the reasons were blatantly discriminatory. Olietta, who was in school at that time composed a song in honor of that event. It was titled simply..."Retribution."

Would it seem ironic that such a gifted and sensitive human being as this should also be a hard-rock miner? Learning and inheriting from her father the skills of geological prospecting, Ms. Moore has often put away her sheet music to don a miner's hat and pick-ax to search for ore in any of her numerous mining claims in the Rockies!

One incident in particular is memorable for her. One day while walking through one of her mine shafts, her son, who was walking with her, idly knocked at the tunnel wall with an iron rod.. this dislodged a boulder which fell in their path. Ms. Moore attempted to move it out of the way, but it proved to be heavier than it looked. Sometime later, she had it and other rocks taken out for use as ornaments in her yard and garden. Recalling the rock's unusual weight, she had a metallurgist test it's mineral content. It turned out to be full of natural gold and silver!

Her mining operations have not recently been resumed, though, because of the wildly fluctuating prices on gold and other valuable ores. Right now, it would make excavation and processing a risky business.

As though this were not enough, Olietta Moore has been often honored for her efforts and achievements in the Denver community. Her affiliations and awards are here summarized:

* Honored employee at the North American of Chicago Insurance Corp.; Award for "Outstanding Production" in 45 years with the company; Special citation by the Corporation's President.
* Member of the "Denver Symphony Guild." She has long helped promote it's "Concert Series," and introduce top name concert talent.
* President of the Mother's Council; Glenarm YMCA.
* Organizer of the YWCA Building Fund.
* Member of the Urban League.
* Member of the NAACP.
* Introduced over 27 different nationalities to the Denver Cosmopolitan Club; promoted racial relations within.

In her special musical programs for the Denver Public Schools, which is called "Operation Talent," Ms. Moore received an award for her presentation; "The History of Negro Music." This was a

musical performance which explored the differences between African music, Early American music, and how they have changed throughout the years of cultural diversification. She is still very active in this program, and in April, plans to attend "The Music of Israel," which will explore the folkways and history of Hebrew music.

If versatility is a prerequisite for distinction in life, then Ms. Olietta Moore certainly qualifies. Likewise, if a person's efforts to advance racial understanding and basic humanity are important, then Ms. Moore must be counted again; for Olietta Moore's contributions to the advancement of black womanhood is exceeded only by her enrichment of the history and heritage of Colorado. Her records stand as witness to this.

Photo - C. McCallum

Photo by Amy Ensner

THE DENVER ARTHRITIS CRAFT SHOP

Do you have arthritis? Would you like to make new friends while you learn a craft, and have a place to sell your products? The Denver Arthritis Craft Shop is a non-profit therapy program sponsored by the Arthritis Foundation and the United Way which offers you free materials and instruction in a variety of exciting crafts.

Perhaps you would like to buy a unique present, have a chair re-caned, or place an order for a custom-made item. When you make a purchase at the Craft Shop you have the satisfaction of knowing that the proceeds will help support a program which is the only one of its kind in the nation.

Visit the Arthritis Craft Shop, 1034 South Gaylord, any weekday between 10:00 a.m. and 5:00 p.m. Browse first among the hundreds of beautiful, reasonably-priced articles displayed in the front of the shop, then wander further back, among the looms and work tables, where you will almost certainly find a class in session. One day recently I watched, fascinated, as instructor Marian Marcks helped a patient put the finishing touches on a leaded-glass version of the Colorado State flag.

The shop also offers classes in silk screening, silversmithing, enameling, weaving, ceramics, macrame, chair caning, sewing, and woodworking. All of the instructors are volunteers who donate their talents and energy to the patients and seem to enjoy themselves a great deal in the process.

Mrs. Kathryn Corley, the shop Manager, talked enthusiastically about the goals of the program.

"The purpose is not to make money," she said. "We help patients keep busy, feel a part of society, and socialize with others who have the same problem -- arthritis."

"There are 80 patients in the program now, and I would like to see this place wall-to-wall with people." Her arm swept a wide arc around the shop. "We have room in all of our

classes. If I need to, I'll get more instructors. We want to reach everyone we can."

Arthritics need not come to the shop in order to benefit from its program. The Craft Shop employs a full-time driver who will deliver materials to home-bound patients and pick up completed craft items to be sold. Patients who wish to attend classes but need transportation are driven (free) to the shop.

The driver is a cheerful woman named Faye, who shared the enthusiasm shown by all those associated with the program. Faye discovered that one of her riders could not climb the stairs to her home. Now Faye simply picks up the woman and carries her safely to her door.

The Denver Arthritis Craft Shop was begun in 1956 at the instigation of Denver Rheumatologist Charley Smyth and his wife, Laura. Dr. Smyth was concerned by the number of patients he saw daily who were discouraged and had lost confidence in their ability to be independent. The shop originated as a "back to work shop" to give arthritics the skills and confidence needed to return to their jobs and homes. The shop now stresses the social benefits to the patients of meeting and talking with other arthritics while learning a new craft.

Mrs. Elsie Hill has been a patient-worker at the shop for several years. During a visit to her West Denver home, she proudly displayed a wide assortment of craft items, many of them her own "inventions." Her hands, although crippled, were perfectly manicured, the fingernails painted a modest shade of pink. She gestured at a small pair of pliers lying beside her. "This is my good right hand," she joked, and she demonstrated how she uses them to pull the needle through the cloth when she sews. In spite of her crippled hands, she lovingly turns out a never-ending stream of dolls and stuffed animals, never able to fill the demand for her items in the shop.

Some of the patients have become self-supporting as a result of their new skills. For others, the principal benefit is the chance to make new friends and express themselves creatively.

Hank Gentsch, a well-known Denver woodcarver who received his training in the shop, was perhaps speaking for all of the patient-workers when he explained in a letter published in the Denver Post some years ago what the shop meant to him.

"To acquire new skills, to see others rise above their difficulties, to create masterpieces of handicraft in spite of disability..these things become an incentive, a practical therapy for the mind as well as for the hands."

* * * * * * *

For information about the Craft Shop, or to enroll in classes, contact Mrs. Kathryn Corley, 744-9278.

by
Mary Mitchell

Hazel Atkinson

FANTASY

Age-old
Mysteries moan
And sob in the tree tops
Through faint whispering
Cadence of
Night-winds

WINDOW TO THE HEART

One small
Window may frame
A Universe of stars. . .
Or open to the blackness of
Deep night.

LISTEN!

Aha!
Can you hear the
Sly laughter of Springtime
Behind the sodden, frayed cloak of
Winter?

GIFT

Roses,
Breath of summer,
Open their fragile hearts
In perfumed essence, giving all
To life.

WEAVERS

People
Are but shuttles
Weaving frail threads of life
Upon Time's loom to fashion
His design.

Salute

My frail friend of the quavering hands
has just painted a portrait of a child
which she sold.

Buoyant,
she glories in life,
knowing the thread which guides her
is slender.

Holding tenaciously,
she drinks of the cup it brings up
living each moment
with a joyous eye.

- Edith H. Brown

Scribes

Battle Hymn of the Aging

We reach the age of sixty-five
Our golden years are here.
They tell us that the age begins
A happy new career.
For now our Uncle Sam becomes
Our permanent cashier, as we go marching on.
Glory, Glory, Hallelujah as we go bravely on.
Our Social Security from Baltimore is sent
We buy a little bit of food, and maybe pay the rent
And after that we're stoney brook and left without a cent
But we go bravely on. Glory, Glory, etc.
And as for checks from Medicare
Will someone tell us how
They always find some doctor bills
They sadly disallow
And dental cost, as well we know, they wholly disavow
But we go bravely on. Glory, Glory, etc.
We don't know how to make it
As we live from day to day
With income fixed and prices up, there is always more to pay
So, minding our arthritis, let's get on our knees and pray
That we go bravely on.
Glory, Glory, etc.
And first of all, let's thank the Lord that we are still alive
The dreams we have may still come true,
When we are ninety-five
So please, Dear Lord, give us the strength our troubles to survive
As we go bravely on.
Glory, Glory, etc.

Mrs. Vit of New Jersey / Acknowledgements to Mrs. Norma McCone and Jeffco R.S.V.P.

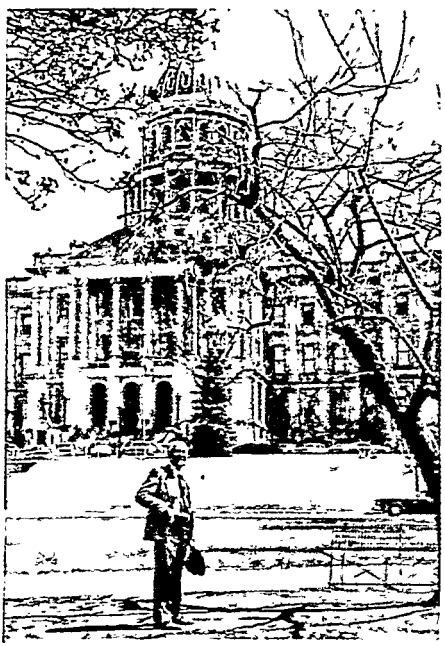

Photo by R. Heath

Dr. William Hines

by
Susan Neville

One doctor's personal search for meaning has evolved into a new program for the elderly and disabled at Swedish Medical Center - a program to enhance independent living.

We must first talk about the man behind the program, Dr. William Hines. During the illness of his mother in the mid-60's, Dr. Hines was more personally involved in nursing homes than ever before, and saw first hand the inadequacies of the health care delivery system in the nursing home area. "Probably because my own mom developed a slight stroke with personality changes in the early 60's, it became apparent to me by the middle 60's that there was a tremendous need in this field. So, I gradually worked my way into this."

SCRIBES: What is the technical title for a doctor who specializes in geriatrics?

DR. HINES: The technical title is a geriatrician of which there are less than 300 in this country. We don't have any license, anything to hang on the wall. I personally happen to be an internist of many years practice who for the last ten years has devoted his entire life to this field.

SCRIBES: Why did you decide to go into geriatrics?

DR. HINES: I wanted to go into something that people weren't doing. It just seemed to be a field that the doctors didn't like. There have been no teachings on the problems of the elderly. There are 18,000 pediatricians; there are 300 geriatricians.
A geriatrician really doesn't have a name yet. But people now realize that medical schools will have to teach this more - even out here at the University of Colorado they've decided to start - not a whole chair, not a whole department, but at least they are planning to teach some geriatric medicine.

SCRIBES: What have you done in your research that would interest our Scribes readers?

DR. HINES: Research-wise, practically none as you would think of it in the formal state. Research has been at the clinical level where we have been trying to determine, through grants and studies with groups like the Colorado Foundation for Medical Care, what is good medical care, and in the nursing homes, and an attempt to upgrade the facilities.

Now as we are into independent living, using other than just pure physicians, we're trying to do things on human need necessity, not just medical necessity. This consists of redeveloping the nurse practitioner program here in the state. We're now using activities people, therapeutic activities people. We're trying to blend together a whole group who can handle the "whole man." Therefore, facilities, medications, and care, and the team to do it is the kind of research we've done, all at the clinical level.

SCRIBES: Would you explain the "meals on wheels" program?

DR HINES: In conjunction again with a need, plus the fact that as we set up SGHR, Swedish Gerontology Health Resources, Inc., it became apparent that one of the first places we could start with was the nutrition field. Swedish Medical Center was committed to it, the Inter-State Task Force based out of the Sheridan area under Maida Navis had all kinds of files on people, plus the transportation. So, we felt that it would be better if they brought people to us, rather than us take the meals out to the people. So we have instead of "Meals on Wheels" we have "Wheels to Meals." And around this we develop activities and a sharing plan.

SCRIBES: Do many people take advantage of the program?

DR. HINES: We can handle around forty-three, three times a week - Mondays, Wednesdays, and Fridays. However, we're looking for ways to enlarge this.

SCRIBES: May I now ask you what diseases are particularly frightening for the aged?

DR. HINES: I'd say cancer, strokes, and senility, in that order. Cancer scares them as much as anything, but if all the cancer stopped tomorrow, the average length of life would only go up 2.9 years. However, if every case of hardening of the arteries and strokes would go out, the average length of life would go up about 15 years. The other thing they fear is senility.

SCRIBES: What is the life expectancy now for our elderly in the U.S.?

DR. HINES: It's up to 75 years for the ladies, and 68 years for the men from the time of birth.

SCRIBES: Any special reason why females live longer than males?

DR. HINES: Females have to be a little tougher, and I think the need to exist. And until recently, they've not been in as much of a stressful situation.

SCRIBES: Thank you, Dr. Hines. Finally, I'd like to ask you whom you most admire in your field.

DR. HINES: In geriatric medicine, I suppose Irving Wright, after whom the first chair in geriatric medicine has been set up at Cornell in New York. I also admire Dr. Ewald Busse, a psychiatrist who first set up the Aging Center at Duke University; he's excellent.

We, too, think that "excellent" is an adjective to describe you, Dr. Hines, and your tremendous work. From all the people whom you have helped to lead a deeper, more independent life - thank you.

Photo by N. Broskey

BALL LIGHTNING

by
C. L. Stites

Did you ever see a real display of "Ball Lightning?"

Many people have reported seeing large or small balls of fiery light break away from streaks or flashes of lightning and strike various objects - sometimes harmlessly and sometimes with devastating results. I have seen a few of these since I have spent all of my seventy years in the western United States, from Mexico to Canada.

Only once however have I been privileged to see a storm of beautiful and harmless ball lightning. That was fifty-five years ago and didn't impress me with its beauty until later as I was frightened "out of my wits" at the time. Although I did not know what the phenomenon was called until I discussed it with an "Old Timer" the following day. It was his second ball lightning observation in a long lifetime. He said that his first was on the plains of Kansas in the late 1800s.

The darkest night I ever saw, I was riding a coal black horse along a narrow county road in the Ozark Mountains of northwest Arkansas. Wire fences extended along either side of the road, and trees and brush were thick on both sides. A continuous rumble of thunder arose from the approaching storm clouds and occasionally burst into a heavy explosion.

The lightning began by flashing all across the sky, from west to east, and lighting every detail of the landscape. Fingers of lightning spread out and enveloped every square foot of the skies within the horizons. It appeared to descend to the earth in a sheet and to strike everywhere at the same time.

Nothing seemed to burn or shatter however, and the display left no visible evidence of damage. Balls of fiery light the size of basketballs clung to branches of trees and some about the size of a large cantaloupe skipped along the wires of the fences. Some of the larger balls of light rolled along and across the road.

I was only modestly frightened until one of the fingers of light appeared to strike my horse's head. Then I waited for him to fall dead and expected to join him. Balls of the fiery light, the size of grapefruit, clung to each of the horse's ears and one rolled along his neck and dissipated against the saddle.

Strangely enough, the horse continued his pace as if nothing unusual was happening and I sat in the saddle awaiting the flash that would snuff out both of us. It never came. The display lasted only a few minutes and I arrived home by the time the rainstorm reached us. I still wonder why that horse wasn't frightened.

Of all the thunderstorms I have observed in my seventy years, no other produced anything that even remotely compared to that one.

ABOUT THE AUTHOR

Charles Stites was born in Arkansas and has been a Denver resident for many years. During his life, Mr. Stites has worked variously, as a farmer, logger, and carpenter. Despite the often strenuous hours put into these occupations, Charles Stites has always made time to devote to writing; as a result, he has had several technical farm-related articles printed -- but that is not all.

The following record of writings would suggest that Mr. Stites is as prolific as he is versatile. He was recently published in Harper's Weekly. Here, he examined some of the customs and sayings particular to Arkansas' history. An avid student of the world of psychic phenomena, he is presently nearing completion of a book which examines his explorations in this area. In addition to these, Mr. Stites has long been an outspoken advocate of water conservation measures in the desert southwest; he sees certain dam projects as being the only hope for utilizing land which is neither aesthetic nor productive in its present state. His comments can be read in the Denver Post.

As you can see from his story "Ball Lightning." Charles Stites is still an active and creative force in his retirement years. We at Scribes hope that he will continue to contribute to this publication, and thereby be a source of inspiration to the senior community of Colorado.

SERVICES DIRECTORY

INFORMATION AND REFERRALS

Adams County Dept. of Social Services, 4200 E. 72nd Ave.....287-8831
Arapahoe County Dept. of Social Services, 5606 S. Court Pl.....798-8461
Boulder County Dept. of Social Services, 3400 Broadway.....441-3870
Colo. Assoc. of Homes for the Aging, 234 Columbine St.....320-4046
Consumer Fraud, 655 S. Broadway.....777-3072
Federal Information Center, 1961 Stout St.....837-3602
Gray Panthers, 1400 Lafayette.....832-5618
Greater Park Hill Information, 2823 Fairfax St.....388-0918
Jefferson County Dept. of Soc. Services, 8550 W. 14th Ave.....232-8632
Mulroy Senior Citizens, 3550 W. 13th Ave.....892-1540
National Council on the Aging, 1020 15th St., #300.....892-9660
Older Americans, Inc., 1578 Humboldt St.....832-9456
Region III Office on Aging, 1766 S. Jackson, Suite 200.....758-5166
Social Security Benefits (Mecicare/Medicaid), 17th & Arapahoe....232-3650
United Way Info. and Referral, 1375 Deleware St.....573-6666

NUTRITION

1st Baptist Church, 14th & Grant.....892-5661
1st Southern Baptist Church, 1595 Pearl.....832-7919
Aurora Senior's Nutrition Program, 1523 Emporia.....364-5651
Food Stamps--Aurora, 1553 Clinton.....364-2646
Boulder, 3400 Broadway.....441-3860
Commerce City, 5600 E. 72nd Ave.....892-3241
Denver, 2855 Tremont.....573-1947
Englewood, 3141 S. Broadway.....892-3235
Jefferson County, 8550 W. 14th Ave.....232-8632
Westminster, 3291 W. 74th Ave.....427-2607
Little Flower Community Center, 2809 Larimer.....623-1476
Jeffco Action Center, 1339 Balsam.....237-7704
Meals on Wheels--Arvada.....424-8756/424-5794
Denver.....832-3004
Golden.....279-3538
Lakewood.....424-7874
Meals for Seniors/Shut-Ins, 3268 W. 32nd Ave.....433-3303
Our Savior's Lutheran Church, 915 E. 9th Ave.....831-7023
QLE Senior Citizen, 450 S. 4th Ave., Brighton.....629-2120
Retired Senior Volunteer Program, 10030 W. 27th Ave.....232-4442
Salvation Army Multi-Service, 2915 High St.....534-7631
Volunteers of America, Senior Nutrition Program, 1865 Larimer....623-0408

TRANSPORTATION

Aurora Senior Citizens Center, 1523 Emporia.....364-5651
Inter-Faith Community Services, 2025 W. Mississippi.....922-8173
Jeffco Action Center, 1339 Balsam.....237-7704
Platte Valley Action Center, 3607 W. 14th Ave.....534-7244
QLE Senior Citizens, 450 S. 4th Ave., Brighton.....659-2120
R.T.C. (Bus Information).....778-6055
Senior Surrey, 2800 S. Platte River Drive.....761-1140
Senior Travel Program, 1705 Gaylord.....297-3043

The following brochures, included in this exhibit, are on file at the U.S. Commission on Civil Rights:

1. "Ongoing Workshops & Lecture Series for Seniors," offered by Metropolitan State College

2. "Summer 77: Learning for Living," Metropolitan State College

3. "Lunch and Learning," Winter/Spring '77, Metropolitan State College

4. "Freedom After Fifty," Metropolitan State College

5. "Untangling Legal Problems For Older Adults," Metropolitan State College

Exhibit No. 10

UNIVERSITY OF COLORADO
MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80262

August 12, 1977

COLORADO GENERAL HOSPITAL
COLORADO PSYCHIATRIC HOSPITAL
CHILDREN'S DIAGNOSTIC CENTER
SCHOOL OF MEDICINE
SCHOOL OF NURSING
SCHOOL OF DENTISTRY

Mr. Arthur S. Fleming
U.S. Commission on Civil Rights
Age Discrimination Study
1730 K Street, N.W.
Suite 214
Washington, D.C. 20425

Dear Mr. Fleming:

We recently had the opportunity to testify before you in Denver in regard to the Age Discrimination Study being carried out by the U.S. Commission on Civil Rights. Unfortunately, the limitation of time did not permit us to share with you the following additional information and suggestions pertaining to age discrimination of candidates to health professional schools:

1. For the benefit and protection of the public, we suggest that there has to be a reasonable, flexible ceiling as to the age that students are selected for admission to a professional school. It does not appear to be reasonable to admit a 60-year old man or woman into a medical school program that requires seven years of preparation at a cost of well over $100,000, if the return in services to the public is likely to continue for a period less than ten years when a similar investment in a 20-30 year old will provide a useful professional life of well over 30 years. For this reason, it is necessary to consider establishing a reasonable upper limit for the age of admission to medical or other health professional school, even though this may have to be done in a relatively arbitrary manner which will, in itself, be considered to be discriminatory by some. Accordingly, we respectfully suggest that the U.S. Commission on Civil Rights recommend that:

> "All requirements for admission to a health professional school should apply to all applicants regardless of age. As evidence that age discrimination is being avoided, the ratio of those accepted

to those applying for admission to a health professional school should be the same for all age groups* unless: 1) it can be shown that individuals of a particular age cannot perform the functions and activities of the health profession to the same degree of skill and competence as the average of all those admitted; 2) it can be shown that the attrition rate during the period of professional training of a particular age group is appreciably (at least four times) greater than the attrition rate for the total group of students; or 3) the number of years that an individual of a particular age might be expected to practice his/her profession will be so few that it would be unreasonable to accept them for training in the health profession.

"The determination of the 'reasonable' upper age limit of acceptable applicants for a particular health profession should be set by a committee or commission whose members include public representatives, member(s) of the U.S. Civil Rights Commission concerned with age discrimination, members of the affected profession, and older individuals who have completed the course of study in that profession."

2. There is no evidence that older individuals entering a profession are more likely to be interested in or more competent to serve as health care providers for the older members of our population than health professionals who were appreciably younger at the time they began their formal training.

   As we pointed out when we appeared before you in Denver, we have found that older as well as younger individuals can be effective and competent health care providers for young children; similarly, we believe that young as well as older health professionals can be competent health care providers for those members of our population who are older.

*An "age group" may be considered to consist of all individuals with ages within an age span of five years.

We have recently been involved in developing a program to train a new type of primary care medical practitioner to be a specialist in geriatrics and our preliminary data suggests that young women may be the one group most likely to be interested and effective in the role of geriatric health care providers.

3. We also suggest that the Commission should recommend that some type of incentive system to health professional programs be provided (particularly to those programs that do not require long and arduous periods of preprofessional and professional training) so as to encourage the programs to accept older candidates for training as health professionals. The method of "encouragement" might be through the use of bonuses, capitation grants, and other financial incentives in a manner similar to that presently being employed to increase the number of medical students and residents who will serve as primary care providers in underserved areas.

   Financial incentives would be particularly appropriate to increase the acceptance of older citizens from rural and other underserved areas since these older individuals are usually more firmly established in the community where they reside and would be more likely to return to these areas to practice than would be the case of those who are younger.

Please call on us if there is any other data or information that you would care to have. Our medical center has been very concerned that we deal fairly with older candidates for admission to our professional schools, but have tried to balance our concern for the applicants with our obligations to the public as a whole. We believe that we have found an equitable solution and trust that our experience will be of value to the Commission.

Sincerely,

Henry K. Silver, M.D.
Associate Dean for Admissions

Harry P. Ward, M.D.
Dean, School of Medicine

HKS/HPW:hc

cc: Ms. Eileen Bradley
Director

ENROLLED STUDENTS BY AGE GROUP
(Preliminary Stats)

RICHARD LOOSE

7-12-77

CATEGORY	F'76	F'75	F'74	F'73	F'72
UNIV. COLO @ BOULDER					
<25	16,244	16,801	17,113	16,694	17,227
25-34	3,959	3,720	3,578	3,464	3,368
35-44	656	645	604	604	591
45-54	173	162	147	137	167
55-64	27	23	19	18	18
65+	2	3	4	7	6
GRADUATES, <25	1015	1189	1085	1018	1043
25-34	2374	2309	2228	2196	2135
35-44	513	484	444	467	440
45-54	136	124	109	103	125
55-64	17	13	14	11	9
65+	1	0	1	4	4
U/G <25	15,229	15,612	16,028	15,676	16,184
25-34	1585	1411	1350	1268	1233
35-44	143	161	160	137	151
45-54	37	38	38	34	42
55-64	10	10	5	7	9
65+	1	3	3	3	2
TOTAL ENROLLMENT (EXCL. SPECIAL STUD)	21,061	21,354	21,465	20,924	21,377
GRADS	4,056	4,119	3,881	3,799	3,756
U/G	17,005	17,235	17,584	17,125	17,621

University of Colorado — Boulder, Colorado

Data are Fall census date figures

Maria Maney
College of Business — Boulder

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THE CHILD HEALTH ASSOCIATE: A NEW HEALTH PROFESSIONAL TO PROVIDE COMPREHENSIVE HEALTH CARE TO CHILDREN

Henry K. Silver, M.D., *and* John E. Ott, M.D.

From the Department of Pediatrics, University of Colorado Medical Center, Denver, Colorado

ABSTRACT. The child health associate is a new category of allied health professional capable of providing a wide range of diagnostic, preventive, and therapeutic services to children. Working principally in ambulatory settings as colleagues and associates of physicians, child health associates have the knowledge and the skill to care for a large percentage of the patients seen in a typical pediatric practice. Child health associates and similar health workers in other branches of the health professions have the potential to be major providers of primary health care in the future. Evaluation of the pediatric knowledge and the diagnostic ability of child health associates students and interns indicates that they compare favorably with medical students and approach pediatricians in these areas.

Pediatrics, 51:1, 1973, CHILD HEALTH ASSOCIATE, ALLIED HEALTH PROFESSIONAL, HEALTH CARE FOR CHILDREN, PEDIATRIC ASSOCIATE.

THE child health associate program prepares a new category of allied health professional who has problem-solving and decision-making capability approaching those of physicians.[1-3] The program, implemented in 1968, represents a significant modification of traditional medical education since it prepares a nonphysician to give extensive primary care, including diagnosis and treatment, to patients. Working principally in ambulatory settings as colleagues and associates of physicians, child health

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ADDRESS FOR REPRINTS: (H.K.S.) Department of Pediatrics, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver, Colorado 80220.

associates have the knowledge and skill to care for a large percentage of the patients seen in a typical pediatric practice. They can provide a wide range of diagnostic, preventive, and therapeutic services as well as parent and patient education, support, and counseling. Child health associates and similar health workers in other branches of the health professions have the potential to be major providers of primary health care in the future. This paper describes the preparation and evaluation of child health associates and discusses their extensive role as health professionals.

Before enrolling in the three-year child health associate program, students must have satisfactorily completed a minimum of two years of preprofessional college preparation. Accepted candidates receive two years of instruction at the University of Colorado Medical Center followed by a one-year internship. Child health associates can be fully prepared for clinical practice five years after graduation from high school in contrast to the 10 or 11 years of higher education usually required to prepare a pediatrician in traditional medical training programs, or the 8 or 9 years needed for a general practitioner whose postgraduate training is limited to one year of internship.

During the first of the two years at the medical center, students have basic science courses similar to those of medical students in the first two "basic science" years in traditional medical schools. Unlike most medical school curricula, all courses for child health associates concentrate on the practical application to ambulatory pediatrics of factual and conceptual information. Extensive contact with patients begins very early in the program; courses in history taking, physical diagnosis, and problem solving are presented at the beginning of the first year of the course of study, and students have the opportunity to follow their patients for prolonged periods. Most of the basic science courses are taught by pediatricians or other clinicians with special skills in these subjects, thus assuring that the clinical correlations of these subjects receive adequate emphasis. Theoretical and laboratory aspects of the basic sciences are de-emphasized unless they relate to pediatric practice.

Since much of the subject matter covered by physicians during their medical training is applicable to specialties other than pediatrics, or to relatively uncommon, severe, and disabling pediatric conditions, it has been possible to shorten the curriculum considerably by eliminating extensive consideration of these subjects while retaining the essential core of information necessary for a detailed understanding of health and disease. In the child health associate program, emphasis has been placed on a single area of medicine, the health care of the child. This gives the student a greater opportunity to acquire sufficient knowledge and clinical experience in one area of clinical medicine to provide the thorough type of health care desired.

The second year in the child health associate program provides the student with a wide variety of clinical experiences on the wards, in the nurseries, and in the outpatient department, as well as in various community settings such as outpatient departments of other hospitals, neighborhood health centers, child health conferences, and offices of private physicians. Discussion courses, seminars, and clinical rotations provide experience not only in the area of general pediatrics, but also in regard to common problems in subspecialty areas such as otolaryngology, dermatology, allergy, adolescent medicine, and psychosocial problems. Courses are given which present a survey of other areas of medicine and dentistry (e.g., surgery and surgical subspecialties, physical medicine), so that the students have an understanding of the contributions these specialties make to total child care. Throughout the program students participate actively in the work-up, evaluation, and management of patients. They take complete medical histories, perform comprehensive physical examinations, establish differential diagnoses, formulate treatment plans, and perform or assess per-

tinent laboratory studies. Their preparation provides them with an extensive knowledge of various aspects of parent-child relationships, variations of growth and development, and gives them the proficiency to counsel parents in health care and child-rearing practices. They are skilled in relieving children and their parents of anxieties and offering reassurance where it is indicated. They also become skilled in utilizing professional and community resources. (See Table I for detailed curriculum of the first two years of the program.)

Child health associates take part in regular activities of the Department of Pediatrics including departmental seminars, teaching ward rounds, and other functions provided for medical students, housestaff, and faculty. The child health associate program has been developed within the School

TABLE I

CURRICULUM—CHILD HEALTH ASSOCIATE PROGRAM

First Year		*Second Year*	
	Credit		*Credit*
Summer Quarter	*Hours*	*Fall Quarter*	*Hours*
Applied Growth & Development I	3	Medical Genetics	1
Physiology I	2	Medical Surgical Subspecialties I	2
Pediatric Anatomy	4	Otorhinolaryngology	2
Embryology	4	Dermatology*	2
Social Psychology I	2	Pharmacology I	2
Fundamentals of Prenatal Care	2	Clinical Pediatrics I	4
		Interviewing Techniques	2
Fall Quarter		Seminar	1
Pediatric Histology & Pathology	4	Psychosomatic & Emotional Problems I	2
Applied Growth & Development II	3	Spanish IV	3
Physiology II	2		
Social Psychology II	2	*Winter Quarter*	
Nutrition	2	Dermatology*	2
Spanish	3 or 5	Developmental Problems & Mental Retardation	2
Winter Quarter		First Aid—Suturing I	2
Microbiology & Infectious Diseases I	3	Pharmacology II	2
Essentials of Pediatric Pathology	4	Clinical Pediatrics II	4
Applied Growth & Development—Nursery*	4	Medical Surgical Subspecialties II	2
Applied Growth & Development—Well Baby Clinic*	4	Seminar	1
Pediatric Biochemistry I	1	Psychosomatic & Emotional Problems II	2
Social Psychology III	2	Spanish V	3
Spanish	3 or 5		
		Spring Quarter	
Spring Quarter		Dermatology*	2
Microbiology & Infectious Diseases II	3	First Aid—Suturing II	2
Laboratory Diagnosis	2	Pediatric Sexual Problems	2
Pediatric Biochemistry II	3	Laboratory Diagnosis	1
Clinical Evaluation of the Pediatric Patient	2	Physicial Medicine	1
Social Psychology IV	2	Clinical Pediatrics III	4
Normal Development of the Child	2	Medical Surgical Subspecialties III	2
Applied Growth & Development—Nursery*	4	Pharmacology III	2
Applied Growth & Development—Well Baby Clinic*	4	Quantitative Methods	1
		Psychosomatics & Emotional Problems III	2
		Seminar	1
Spanish	3 or 5	Spanish VI	3

* These courses though given more than one quarter are only taken once by each student.

of Medicine where the mainstream of health care training presently exists.

The third year of the child health associate program consists of an internship in child care. The focus is on allowing the trainees to apply and practice skills previously learned, as well as to gain additional knowledge in rural and urban ambulatory settings including neighborhood health centers, migrant facilities, Indian reservations, and the offices of physicians (both pediatricians and family practitioners) in private practice. The internship gives the child health associate practical experience in dealing with the problems of providing comprehensive health care in each of these locations. For more specialized educational and clinical experience, interns also have rotations at a developmental evaluation center, a newborn nursery, and an adolescent clinic. During the internship year interns participate in the assessment and care of more than 2,000 children.

Physicians accept child health associates as colleagues in providing health care and allow the associates sufficient time in their contacts with patients to emphasize preventive pediatrics, anticipatory guidance, and family counseling and health education of all types. The internship prepares the child health associate to assume primary responsibility for patient care and to function with autonomy in making independent value judgments regarding the health care of children. The overall course of study prepares students to give thorough health care to most children seen in ambulatory settings. Students have incorporated a knowledge of their limitations as well as their strengths so they know when to make referrals to physicians for consultation and further management. Child health associate students spend more time in the areas of preventive pediatrics, well-child care and supervision, and in the care of the child with minor illness than is usually spent not only by medical students, but even by most pediatric residents. On completion of the internship the skill of child health associates in outpatient child care is considerably greater than that of any other allied health professional and compares favorably with that of most physicians entering practice.

Child health associates concern themselves and can provide extensive care for the problems of children which occupy much of the time of the physician in practice—respiratory ailments, minor injuries, communicable diseases, minor gastrointestinal disturbances, allergy problems, mild skin disorders, as well as well-child care, various aspects of parent-child relationships, variations of growth and development, and anticipatory guidance. They perform these functions with skill and competence and provide broadly based professional service of a high quality. Associates will not take primary responsibility for the continuing care of children with severe or complicated acute and chronic illnesses which are life threatening or particularly handicapping or for the total hospital care of sick children.

Prerequisites for the child health associate program include one-year college courses in general chemistry, biology, and psychology, and two years of the humanities. Previous employment in a medical field is not required, but a demonstrated interest in helping children is essential. An effort has been made to select students from areas and groups with particularly urgent health needs in the hope that they will practice in these areas on graduation. Those students who do not have a baccalaureate degree prior to admission earn one during the second year in the program. At the end of the third year they have completed the course requirements and practicum (internship) required for a master's degree and need only prepare a satisfactory thesis to earn this degree.

After completion of the three-year program and successfully passing an examination given by the Colorado State Board of Medical Examiners, the child health associates are certified by the Board for employment under the supervision of physicians (both medical and osteopathic) whose practices include a significant number of

pediatric patients. Child health associates practice in two main settings: (1) in various public health facilities in low-income urban and rural areas, and (2) as colleagues and employees of family practitioners and pediatricians in their private offices. At all times the child health associate functions under the guidance of a licensed physician who must be readily available but not necessarily personally present for supervision and consultation as the associates provide patient care in office, home, and hospital settings.

In Colorado, the practice of child health associates is regulated by the pioneering and innovative Colorado Child Health Associate Law, which defines the training, functions, activities, degree of required supervision, and the practice of graduates of the program.* The law limits the physician's authority to delegate duties and specifies that the physician will continue to retain professional and legal responsibility for the care and treatment provided to patients by the child health associate. The law allows no more than one child health associate to be employed at any one time by any one physician. Postgraduate education is required for continued certification.† A delineation of specific legislative controls has been beneficial because it mapped out the enlarged area in which these new health professionals could practice while preventing them from extending their activities beyond their capabilities and beyond reasonable limits.[4]

The duties of the child health associate graduate principally involve ambulatory child care and routine hospital care of the newborn infant. The associate can render services outside of the office or clinic pursuant to specific directions of the employing physician concerning that particular patient. Since hospitalization of pediatric patients, except for the newborn infant, is generally limited to those with serious illness or complex problems, extensive hospital care of children is generally considered outside the realm of practice of child health associates.

Child health associates can diagnose illnesses as well as formulate treatment plans. They may prescribe and write prescriptions for drugs which have been approved by the Colorado State Board of Medical Examiners. This represents the first time in the United States that an individual who does not possess a doctorate degree in a health science is permitted by law to render written prescriptions for drugs. The proprietary and nonproprietary drugs such as immunologic agents, antihistaminics, antidiarrheal agents, and hematinics, as well as diagnostic agents to determine the presence of various diseases that have been approved include the vast majority of those used in the ambulatory practice of pediatrics. In caring for patients and in evaluating social, cultural, and emotional factors as they affect health, the child health associate has incorporated and uses many of the basic skills of the social worker and psychiatrist as well as those of the pediatrician.

A number of studies have been carried out to assess and evaluate the extent, adequacy, and relevance of the child health associates' basic science training, their comprehension of clinical pediatrics, and their knowledge, skills, and competence as students and as practitioners.[5] When first-year child health associate students, medical students completing the first and second year of medical school, and pediatric residents were given identical representative examinations designed to test their knowledge of relevant factual information of the basic

* The first class of nine child health associates completed the three-year program in June 1972. They all passed the examination given by the Colorado State Board of Medical Examiners and are certified to practice as child health associates. Six are practicing in Colorado (four in public health settings and two with family practitioners). They are performing within the full range allowed by the law. The remaining three graduates will practice in public health facilities in other states.

† The Child Health Associate Law as well as the child health associate program have been endorsed by Colorado's medical and osteopathic societies as well as the state chapters of the American Academy of Pediatrics and the Academy of Family Practice.

sciences (anatomy, biochemistry, embryology, histology, and pathology, etc.), child health associate students received higher average scores than the comparison groups; pediatric house officers made higher scores than medical students who had just completed the courses even though the house officers had not taken any basic science courses for approximately five years. These findings strongly suggest that child health associates have a satisfactory understanding of basic science material which is relevant to the practice of pediatrics.

On an examination of clinical pediatric knowledge similar in format, content, and degree of difficulty to that of National Board examinations and developed specifically for the evaluation of medical students, second-year child health associate students demonstrated a degree of knowledge that compared favorably with senior medical students who had completed their clinical rotations in pediatrics. Although attempts have been made to study the clinical competence of physicians,[6] only recently have efforts been made to compare the competence of the newer allied health professionals with that of traditional health personnel. Second-year child health associate students, senior medical students, and pediatric residents were also compared in their ability to take an appropriate initial pediatric history on an ambulatory patient; to perform a complete physical examination using the skills of inspection, palpation, percussion, and auscultation and such tools as the stethescope and otoscope; to derive a clinical impression based on their medical history; to order relevant laboratory studies; to interpret bacteriologic cultures; and to discuss their initial interpretation and the need for further tests with the mother. In most of these areas, the performance of child health associates was more consistently satisfactory than that of fourth-year medical students; pediatric residents outperformed both groups. The results of these studies demonstrated that the performance of the child health associate was highly appropriate and entirely satisfactory for clinical practice and was comparable to that of the other two health professional groups.

In still another study, the comparative diagnostic abilities of child health associate interns and practicing pediatricians was determined. The recorded findings and diagnoses of patients in office settings seen separately by both groups was reviewed and compared. Almost all of the patients were ill with a variety of diseases including upper respiratory infections, pharyngotonsillitis, otitis media, bronchitis, meningitis, mumps, scarlet fever, appendicitis, skin rashes of various types, and croup. In over 97% of more than 143 cases studied, the child health associates' diagnoses did not differ significantly from those of the pediatricians.

COMMENT

An urgent need exists throughout the United States both in rural areas and urban communities for more health professionals to provide increased and improved health care to children. The increasing awareness of the need for adequate health care for children has already resulted in a greater utilization of pediatric facilities and health manpower. Although a variety of attempts presently are being made to alleviate the shortage and/or maldistribution of physicians, none of them seems likely in the foreseeable future to eliminate the shortage of trained personnel. We suggest that much of the present and future needs for personnel to provide broadly based diagnostic, preventive, and therapeutic health care and services to children in ambulatory settings could be met by child health associates.

The child health associate is a health professional who has the background, understanding, proficiency, and competence to assume a direct and responsible professional role in patient care. The child health associate can provide extensive health care to most patients. Within clearly defined limits, he makes value judgments and independent decisions based on his problem-solving abilities and assessment of a clinical situation, and assumes responsibility and

accountability for his decisions and performance. Child health associates serve as associates of physicians with whom they have a collaborative relationship. This is in contrast to many categories of physician's assistants who also work under the supervision and authority of physicians, but have a more dependent position and are not expected to assume the same degree of responsibility for their decisions or actions.

The only other allied health professional whose role approximates that of the child health associate in providing skilled health care and services to children is the pediatric nurse practitioner.[7] Although the pediatric nurse practitioner can, by law in most states, practice independently, she is not expected to give as extensive care to the sick child, is more limited in her understanding of the underlying mechanisms of health and disease, has limited ability to develop a differential diagnosis for the conditions that she manages, and performs fewer procedures.

Child health associates are qualified to provide most of the services now being given by physicians to children in ambulatory settings. Associates could serve as the prototype for a new health professional who would not be a doctor but, in a limited area of medicine, would have the educational preparation, clinical proficiency, problem-solving ability, decision-making capabilities, and potential for independent action approaching that of the medical practitioner with a doctorate degree. The child health associate and other similarly prepared health workers have the capacity and competence to deliver high quality health care and service, and could provide a major portion of primary patient care. They have the potential of being a major addition to the traditional health care system.

An association of a child health associate with a physician significantly increases the number of patients who can be seen by the physician and makes the practice of medicine more satisfying to him; he can delegate to the health associate many functions and activities which do not require his special skill and knowledge. In the new arrangement, physicians serve as teachers and consultants, thus broadening their scope as health professionals and providing them with increased satisfaction with their practices.

REFERENCES

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Life Begins at Sixty at CU

UNIVERSITY OF COLORADO SENIOR CITIZEN AUDITORS PROGRAM

a free, non-credit offering
to all Colorado Residents
60 years old or older

Boulder / Denver / Colorado Springs

Life Begins at 60

How the program started

Recognizing the need to provide greater service to more persons, the University of Colorado Board of Regents in 1973 extended CU's service to many thousands of older citizens in the state by providing an experimental Senior Citizen Auditors Program at the Boulder campus.

Under this enrichment program, which now is a permanent part of the University's offerings and also approved for the University of Colorado at Denver and the University of Colorado at Colorado Springs, any resident 60 years or older may take nearly any course he chooses at no charge. Auditors receive no academic credit for the courses they complete.

Bill Douglas, dean of admissions and records at CU, says the University is vitally interested in expanding the program to include as many older persons in the state as possible.

There is no prerequisite for becoming a Senior Auditor other than age and Colorado residency. No auditor is required to have had any college or university training, or even to have completed high school. There are no tests before or after entering the program.

Anyone in the Senior Citizen Auditors Program may take as many courses as he or she wants to. You may attend class whenever you want to. You may buy textbooks, if you desire, although there is no requirement.

In other words, the Senior Citizen Auditors Program is designed to meet your desires and needs for additional information and education.

How to participate

If you want to join the Senior Citizen Auditors Program at the University of Colorado in Boulder, it's an easy task to sign up.

Registration is held the first Monday and Tuesday after classes start. It's known by this time whether there are vacancies in classes. Notice of Senior Auditors special registration usually is printed in area newspapers.

In Boulder, the sign-up procedure is conducted in Koenig Alumni Center, Broadway and University Avenue, and there will be plenty of assistance to help you get the courses you want—experts from the Admissions Office, as well as a number of retired CU teachers and administrators who have taken an active interest in helping older Coloradans.

On other campuses, registration information is available from the Admissions Office.

If you can't sign up for classes during registration, you can go to the Admissions Office, 125 Regent Administrative Center, after special Senior Auditors registration, to find out what courses are available. Marge Koenig, Joyce Wolsky or Vicky Biggs can give you assistance.

Why register?

For a number of years, some older persons have been informally sitting in on classes. The simplified registration in the CU Senior Auditors program helps the University know the response of older persons. The auditor's card you receive at registration will help you in such places as the libraries. Also, as an auditor, you'll be invited to a tea at the end of the semester in the Alumni Center where you can chat with your fellow auditors and meet some of the teachers active in the program. You also can give your views of the program and the University.

A word to the wise . . . .

When you go to a class for the first time, show your auditor's card to the instructor before or after class and ask him these questions:

—What are the textbooks for the course?

—Is there a supplementary reading list?

—Do you allow senior auditors to participate in class discussions?

—Are there any changes in the meeting times or places printed in the Schedule of Courses?

Any questions?

Possibly you can save yourself a trip to the campus and get all the information you need by telephoning some of the key people who have been working on the Senior Auditors program:

Bill Douglas, 492-7407
Jean Ferris, 492-7885
Marge Koenig, 492-8026
Vicky Biggs, 492-7407
Joyce Wolsky, 492-6463
Mary Panetta, 492-6401
Dean Graves, 492-8484

good luck!

Brochure on Child Health Associates is also part of this exhibit, and is on file at the U.S. Commission on Civil Rights.

Exhibit No. 11

EXHIBIT

CETA-PSE Work Opportunities

In briefly scanning the City of Denver's pay plan, one finds only a limited number of career classes which fall within the $10,000 per year salary limit. The Denver pay plan was used because of ready access. However, since it is based on regional and national survey data, it should reflect some general themes. No criticism of that pay plan is intended. The data is provided to show the unrealistic nature of the $10,000 limit in relation to older workers. The list is illustrative, not inclusive.

The classifications are divided into three groups:

(a) low status, dead end, and/or heavy labor jobs;
(b) entry level clerical jobs; and
(c) exceptions

Group A: Low Status, Dead End, and/or Heavy Labor Jobs

(As can be seen from the title, these classifications entail one or more of the following traits: (a) they are low status, and may deter a person who has worked a lifetime in responsible, meaningful, and reasonably prestigious endeavors; (b) they are dead-end jobs, offering little chance to advance to, or regain, responsible and well-paying work; (c) they entail considerable physical exertion. This last trait has two effects. First, the older worker may not be able to do such work. Second, even if the older worker can do it, the likelihood of discrimination by the interviewer in favor of a "young muscular kid" is significant.)

Illustrative Classes

Auto Parts Clerk I
Boat Ranger/Golf Ranger
Car Washer
Custodial Worker
Garage Attendant I, II
Guard/Watchman
Lifeguard/Pool Attendant/Sports Leader
Parking Enforcement Clerk I
Parking Meter Collector
School Crossing Guard
Seasonal Laborer
Usher I, II, III

Group B: Entry Level Clerical Jobs

(Very few men are trained for clerical work. In practice, most such positions are filled by women. Competition is severe, including that from new entrants to the labor force fresh from high school or business school training. In practice, there is limited upward mobility to higher clerical jobs, and practically no upward mobility to non-clerical jobs. Admittedly, the opportunity for salary and career advancement is greater than Group A.)

Group B (contd.

Illustrative Classes

Entry Level Clerk-Typist, Clerk- Steno, etc.
Cashier
Data Processing Tech. I, II
Graphics Tech. I, II
Hospital Admissions Clerk I, II
Machine Posting Clerk I, II
Stock Clerk I, II
Switchboard Operator I, II

Group C: Exceptions
(There are exceptional cases where such low-paying jobs are not low status and have a reasonable likelihood of leading to higher paying positions.)

Illustrative Classes

Graphic Artist I
Job Coach
Laboratory Assistant
Police Cadet
Pool Manager
Press Operator I

In summary, the $10,000 limit is a genuine barrier to attracting older workers to the CETA-PSE jobs.

Industrial Gerontology

VOL. 2, No. 2 / SPRING 1975

The views expressed in this journal are those of the authors and do not necessarily represent the view of the Minnesota Department of Employment Services or the Manpower Administration of the U.S. Department of Labor.

A compendium of current papers on middle-aged and older workers, published by The National Council on the Aging, and funded by the Manpower Administration, U.S. Department of Labor, through the Minnesota Department of Employment Services.

CETA and The Older Worker: A Planning Strategy For Local Communities

Martin E. Flahive

The author is Deputy Manpower Administrator for the City and County of Denver, Colorado. He has coauthored and edited Denver's 1974 and 1975 comprehensive manpower plans and now serves as the Mayor's Director of Citizen Participation for the planning of Denver's Community Development block grant.

The Comprehensive Employment and Training Act of 1973 (CETA) consolidated a variety of traditional categorical manpower development and training programs.

More importantly, the legislation gave communities the opportunity to determine the level and mix of services without most of the categorical constraints.

One result of the local planning responsibility is that the community can elect to provide *new* services to *new* client groups.

Special projects or services for older persons are generally eligible activities under CETA, but the advocate of such services must be prepared to compete for these funds.

The thrust of this article is to communicate to older persons, representatives of their service organizations and other interested parties some basic information about the Comprehensive Employment and Training Act (CETA); it is not to shed any new light on the special needs of older people. These groups should have information on how manpower block grants can be put to effective use for the benefit of unemployed or underemployed persons classified as middle-aged and older workers (those over age 44).*

The key factors include older workers themselves, their advocates, elected officials, manpower planners and project managers. No attempt will be made to characterize the first three groups;

* The Age Discrimination in Employment Act of 1967 differs from this definition in that it designates age 40 as the time when entry or re-entry into the labor force may be a problem because of age.—*Eds.*

however, a few thoughts on manpower planners and program managers might be useful from one who has served in both capacities.

CETA—A Revolution

CETA was a revolution of sorts. It permitted many communities to enter the manpower arena for the first time, confronting them with the need to recruit experienced personnel to set up a new complex of services. Even communities which had experience in categorical manpower operations generally had no genuine experience in planning and operating a comprehensive system. With the notable exception of municipalities designated as Comprehensive Manpower Planning (CMP) grantees and certain other communities, like Denver, most localities had never wrestled with the need to balance service levels among competing projects and uses. The U.S. Department of Labor (DOL) has for some time made these determinations by its awards of categorical grants, with their concomitant limitations. Thus, the Federal Government left few options to the local officials as to the mix of services.

Then came CETA, and almost overnight practically every community with a population over 100,000 had to develop the capacity for manpower planning and to reflect that effort in an annual plan. One consequence was that the program managers who formerly received grants directly from the Federal Government now had to approach the locality for a share of available resources.

A second consequence, and perhaps the most profound short-term implication, was that the small supply of experienced planners was absorbed quickly, along with a large number of persons totally inexperienced in the state of the art and the political ramifications of manpower planning. In many communities, the project managers were more familiar with the field than were the persons employed to design the system. The hazards are evident.

A serious risk in this lack of expertise is the inclination to avoid analysis of the special needs of certain groups in favor of a monolithic system to serve all. The advocate of special services for the older worker may thus encounter resistance to change of any sort and may lack experience in dealing with managers of entrenched programs.

HIGHLIGHTS OF MAJOR PROVISIONS

It is not possible to brief the reader on all the ramifications of CETA.* Much of what there is to know deals with administrative matters and DOL's role, both beyond the scope of this article. The succeeding notes are intended to make readers conversant with the major provisions of the act.**

Section 2 of the introductory part of CETA states the intent of Congress:

> It is the purpose of this Act to provide job training and employment opportunities for economically disadvantaged, unemployed, or under-employed persons, and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency by establishing a flexible and decentralized system of Federal, State, and local programs.

Generally, prime sponsors are localities with a population in excess of 100,000. Where such concentrations do not exist, the state is usually the sponsor. In either case, limitations on the use of funds deserves attention. The clients must be: (1) "disadvantaged," i.e., poor, on the basis of published income scales, (2) unemployed, or (3) under-employed. The last category is equivalent to the group often termed the "working poor;" as such, "underemployed" is simply a subset of the "disadvantaged" class. In summary, beneficiaries must be either unemployed or poor.

Comprehensive Manpower Services in Title I

Title I of CETA is the "comprehensive manpower services" component. In addition to a general description of the wide range of services eligible under the act (Sec. 101), there is a definition of prime sponsorship (Sec. 102), the allocation formula (Sec. 103), the requirement for local manpower planning advisory councils (Sec. 104) and the conditions for financial assistance (Sec. 105). The balance of the provisions are not relevant for local program proponents at this stage of the game.

* P.L. 93-203, enacted December 28, 1973, amended December 31, 1974. To obtain copies of the act and regulations, the local prime sponsor, the state manpower planning office or the regional office of DOL should be contacted. There will be copying costs for the documents. The alternative is to do some library research. The amendment added the new Title VI Public Service Employment program, so some additional searching may be required. The regulations have been published in several segments in the Code of Federal Regulations (CFR).

** For a description of CETA and its implications for middle-aged and older workers, see Schuchat, "Older Workers and the New Manpower Training Law," INDUSTRIAL GERONTOLOGY, 1(3):81-84, Summer 1974.—*Eds.*

In most manpower systems, the previous categorical programs consolidated under the act were almost exclusively designed for the poor. As might be expected, there is a great deal of pressure exerted by these projects, their clients and others to keep the emphasis on the poor when designing the overall CETA system.

As a result, newcomers may be required to demonstrate how their recommendations will benefit the poor, as opposed to those who are simply between jobs. Generally, to qualify under such a standard, the design must include a training aspect in order to demonstrate the capacity to serve poor persons who are not job-ready. In Denver, the manpower plan calls for 90 percent of the Title I clients to be poor, and so a program purporting to serve non-poor has only a slim chance of surviving the struggle.

Public Service Jobs in Target Areas

Title II creates public service jobs for unemployed persons residing in selected poverty areas within a limited number of communities. Two issues are worth attention. First, do older workers receive a fair opportunity to compete for these positions designed for job-ready persons?* Second, can such positions be utilized to staff or assist in services designed for citizens over age 44? Sections 201 through 204 give ample information on the nature and scope of this article.

Special Federal responsibilities are outlined in **Title III**, divided into two sections. The latter deals with innovative research and evaluation activities not germane to this article, but the first section is relevant. Here, Congress has identified several special target groups, including youth, American Indians, migrant workers and older workers as "segments of the population that are in particular need of such services" as are offered in Titles I and II (see Sec. 301). In Section 304, the older worker is again mentioned, and the Secretary of Labor is specifically authorized to provide financial assistance for "special programs... directed to the needs of those chronically unemployed poor who have poor employment prospects and are unable, because of age ... to secure appropriate employment or training assistance ..."

DOL has not, to date, taken any action to implement Section 304. No allocations have been made, no regulations published. At

* It is important to note that the recent extension of the Age Discrimination in Employment Act to cover employees of state and local governments applies to all Title II and Title VI programs.—*Eds.*

one point, there was a debate over whether such projects should be funded through CETA Title III or through the Older Americans Act, since both address essentially the same clients and services. It is now my understanding that CETA Title III will be the funding vehicle. Such deliberations cause regrettable delays in needed funding.

Manpower Policy Commission Established

Title IV brings the Job Corps under CETA but makes no substantial changes in the thrust of that program. Section 401 details the Job Corps' purpose and scope. **Title V** establishes a "National Commission for Manpower Policy," described in Section 501. The rest of Titles IV and V are largely irrelevant to the matter at hand.

The new Title VI establishes a public service employment program not limited to target areas. It is intended as a response to the prevailing economic situation, thus designed as a temporary mechanism. In all other material respects, it resembles Title II, though the reader may wish to review Sections 601 through 603.

Title VII deals with general provisions of the act, including definitions (Section 701) and other special conditions and limitations. Certain definitions do warrant the reader's attention (e.g., "unemployed" and "underemployed") though generally they are more detailed than most readers will require.

PROVIDING SPECIAL SERVICES

Let us assume that the older worker has a unique set of manpower needs, including specially designed recruitment activities, well-trained staff for supportive services and job development, retraining opportunities and career counseling which helps the individual to relate work background to new training options.

Strategies for delivering these services are many; however, a word of caution is in order. To properly design a manpower system, planners must divest themselves of preconceived notions about which projects or organizations ought to do what. The needs of the total client community must be considered, and toward that end *all* alternative delivery systems must be considered.

Further, the planner must balance thoroughness with practicality (see chart). An older worker advocate may discuss with manpower planners a particular service design managed by a particular oganization. He or she may emerge from such a discus-

CONCEPTUAL MANPOWER SYSTEM

Here is a simplified schematic of a full-service manpower system. Most communities will need some assistance in developing recruitment, supportive services and job development for older workers. Also, employment counseling and treatment services are too expensive to duplicate in each project, but other elements in the plan could be either centralized or decentralized, depending on local conditions.

sion with the desired services—but perhaps delivered by a different agency than the one expected—and not in the original configuration. The service should be the objective, not the perpetuation of a given organization or staff. Those who purport to concern themselves with the needs of older persons must be prepared to make sacrifices in order to institutionalize older worker services by "integrating" the entire manpower system.

Furthermore, the community must give special attention to the integration of services into one durable system. CETA is not simply a pool of money for disjointed projects; it is an opportunity to develop and maintain a comprehensive complex of community services. The project mode is, or should be, a thing of the past.

MANPOWER TRAINING FUNDS WILL DECLINE

In most communities, Title I of CETA is the primary source of funds for manpower training and related employability development activities. (Though the public employment programs under Titles II and VI frequently involve large sums of money, they deal largely with displaced, job-ready people.) Training and retraining are most frequently undertaken with Title I resources.

Most large cities, and many other communities (classified as "hold harmless" prime sponsors) will receive *gradually reduced* allocations of Title I funds over the next few years, assuming that Congress does not increase the overall funding level for CETA. Strategically, this poses a real problem for the newcomer in such a community. If there are already established programs, a high level of competition for these diminishing funds can be assumed, and the situation will be aggravated with time. If one wishes to affect the system design it is best to do so *now*—or be faced with impossible barriers as the funds are reduced in years to come.

LOCAL STRATEGY OPTIONS

In attempting to break into the CETA arena, the advocate of older worker programs should be able to offer some suggestions to local manpower planners. The approaches are as numerous as the problems of older workers. However, one's strategy should be tailored to the unique political and organizational factors prevailing in the local manpower scene.

In many communities, there are older worker projects now in operation which offer some semblance of manpower services.

If they are successful and appropriate to local needs, the community may wish to integrate such projects into the larger manpower system. In some cases, it may mean a long-term financial commitment, so the manpower planner will have to keep in mind a balanced program mix when considering such an option.

The advantage of utilizing an existing project is that it is functioning and has had some operational and administrative experience. Most importantly, the project usually has an established clientele of eligible persons, as well as others who can assist in reaching out to more clients. Among the disadvantages are the probable lack of experience in the full range of manpower services, plus unfamiliarity with legislative and regulatory constraints. In addition, there is a risk in that attempts to bridge gaps in the program may result in excessive duplication of services. Though these disadvantages are not insuperable, they warrant evaluation when comparing options.

Creation of New Service Facility

Where there are no older worker programs in operation, a second course available is the creation of a new service facility, either as an extension of the governmental structure or under contract with a local organization. Where no programs are in existence, this may have the advantage of filling the gap with a custom-made program designed specifically for local manpower needs. On the negative side, there is a risk similar to that in the first option—namely, duplication of certain services already available in the community. Furthermore, experienced manpower managers know that a new project takes time, often years, to gear up to its full potential due to staff inexperience, training needs, lack of on-hand clientele and the elaborate linkages required.

Some explanation of the concern about "duplication" may be helpful. Many elements of a total manpower program are long established and well-tested devices. In many communities, such services are already being delivered by competent agencies. But I have observed a tendency on the part of project directors to try to bring all required services under one leader and a single roof. Such efforts consistently prove to be expensive, wasteful and practically impossible. The waste is that half of the services needed in a comprehensive manpower system can be delivered to everyone in essentially the same way. The other half are unique to each client sector. When the former services are replicated in every agency, the cost/effectiveness relationship is adversely affected.

On the other hand, duplication of certain scarce resources is not inherently wrong. Thus, having several projects operating in the same vicinity isn't inherently wasteful unless each director insists on administering the resources best operated centrally.

Examples of services whose duplication is at least suspect include: Adult and basic education, skills training, work experience programs, job information clearinghouses, planning and research. Proliferation of these activities is always expensive and generally does not result in improvement in quality (the reverse is often true). Services generally performed best at the project level include recruitment, supportive services, counseling and job development, though the latter is subject to reservations regarding coordination.

Modify Existing Manpower Programs

A third option is open to local manpower officials. There are often existing manpower projects in a community, such as the State Employment Service, Operation SER (Service, Employment and Rehabilitation), Opportunities Industrialization Center, Concentrated Employment Program and the local Community Action Program (CAP) agency which are already drawing on CETA resources. To what extent can they be modified to serve, or better serve, older citizens? The tripartite task is to

- sensitize both management and staff to the special needs of such clients
- attract the clients to apply
- provide them with a tailored package of services.

Existing agencies have the advantage of experienced (and hopefully viable) organizations with certain standard on-going services. Characteristically, though, these projects have been unable, or unwilling, to attract clients in the upper age groups; consequently, a simple change in quotas will not by itself change the profile of clients. Denver is a case in point.

In planning for the 1974 fiscal year, we found that only about one percent of our clients throughout the manpower system were over 44 years of age. The 1974 plan reflected a target of 10 percent. At the end of the year, having changed nothing but our projections, the level was only one-and-a-half percent. Even that small change may have been a statistically random fluctuation.

Likewise, simply modifying the training provided to counselors does nothing if older clients don't feel comfortable in seek-

ing assistance from the program. It appears that attempts to "integrate" an existing system must not only involve goal setting but must also include an analysis of success criteria, in-service training, effective recruitment and sensitive treatment throughout the network—all the way to job development and placement.

Establish Formal Linkages

A fourth direction, capitalizing on the best aspects of the previous approaches, is the establishment of formal linkages with existing projects serving older persons. The idea is to let such projects do what they do best (e.g., the recruitment and provision of supportive services) in concert with agencies providing the more generalized manpower services. One means of effecting this balance is to have a formal agreement (financial or otherwise) whereby the recruitment agency, such as a senior center, would be responsible for contacting and screening older clients. Those meeting the eligibility requirements would be referred to a general-purpose manpower program giving preferential treatment to such clients.

Ideally, this general-purpose center is also under contract to, or otherwise under the control of, the locality. The staff would have to be motivated to give special priority to these referrals; to submit to specialized training, and to report client progress to the originating agency to assure improved referrals on the basis of such feedback. If the projects are not cooperating properly, the manpower system director can use the supervisory or contractual authority to regain harmony. The locality therefore plays the crucial role in orchestrating this relationship, and here is where such plans most often fail. The officials must have the resolve to undertake such coordination and to resist the normal efforts by project managers to "spread out" by in-house duplication of services that can be provided by other actors in the system. The result may be continuing rivalries requiring firm management.

The four options described are not exhaustive, but they do illustrate the fact that no choice is free of difficulties. The selection must be made in terms of the local political environment, the state of the manpower system in the area and the personalities and priorities of manpower managers and planners.

Compromise Essential to Effective Strategy

In developing an effective strategy, older workers and their

advocates must present a clear picture of their objectives, recognize the practical limitations of the manpower planners and, in the last phases of joint planning sessions, be willing to compromise to bring about a sound manpower system that will adequately serve older workers and assure them a fair share of services.

Though Denver's plan is not yet operational, it will probably utilize the third and fourth options, i.e., using existing projects for selected services (e.g., outreach) while providing special training to the staffs of existing manpower vendors. This course of action was tentatively selected only after the foregoing analysis.

INFLUENCING LOCAL PLANNING

If a person or organization is interested in influencing local manpower policy, some homework is in order. As already mentioned, the competition for these funds is aggravated by the pattern of declining resources. To compete effectively, it is important to act now and to be armed with tools appropriate to the task. There are at least six measures one can take to develop a competitive position:

- **Read the act.** Though CETA is lengthy, a review of the key sections of the act and regulations as outlined earlier requires approximately an hour's reading.
- **Identify the prime sponsor.** In a large city or county (i.e., over 100,000 population), the odds are that an agency of that municipality is administering CETA activities. In smaller jurisdictions and in many rural areas, the state has a "balance-of-state" responsibility for managing CETA. The third alternative is that a community may have entered into a consortium for the joint planning and operation of the CETA grant. One thing is certain: There *is* a prime sponsor, and that fact is the starting point. If in doubt, contact the state manpower planning office or regional DOL office. Both are responsible for ongoing communication with all sponsors in the respective territories. It is essential, above all, to know the audience.
- **Determine what the prime sponsor is doing for middle-aged and older workers in the area.** Where, if at all, do middle-aged and older workers fit into the present manpower plan? Are they given any priority? Are the proposed services appropriate to the local needs of that age group? If older workers are not

addressed in the plan, were they given any consideration in the planning deliberations, and, if so, why they were not given specific attention?

- **Offer assistance.** Regardless of the area's present state of planning, now is the time to begin influencing plans for Fiscal Year 1976 and beyond. The assistance might be in various forms, such as technical assistance, research, staff training and literature. Whether the chief elected official or the manpower director should be approached is a matter of individual local strategy.
- **Seek a permanent relationship with the jurisdiction's manpower planning office.** It may be possible to persuade the elected official to put an older worker representative on the local manpower advisory council. At a minimum, there ought to be an opportunity to make a formal educational presentation to the local council to inform members of older clients' special needs. Perhaps local manpower planners and their counterparts in senior services can formalize an ongoing liaison. It should be ascertained if there is a local commission on aging and the role such a group might play in influencing manpower programming.
- **Do the necessary homework.** In addition to having a speaking acquaintance with CETA, one ought to have a general familiarity with the Older Americans Act, the Age Discrimination in Employment Act and appropriate regulations. Such preparation will be useful in efforts to affect local policy.

A person armed with the above ideas has at least a fighting chance to find the right people, say the right things, and spark action for older persons in need of manpower assistance. Unprepared, the advocate can expect to be ineffective, and the opportunities offered by CETA will be lost.

The spirit of cooperation is important. An aggressive advocate for older workers, or any special client group, can still work in harmony with the other principal actors in the manpower cast. I have been impressed with the caliber of manpower planners I have met and happy to note how few are idle bureaucrats. Local manpower planners may be beleaguered and bewildered at times, but in general I have found them to be dedicated and talented public servants. □

WOMEN AND CETA in the STATE OF COLORADO

A Women's Needs Assessment Study and A CETA Program Evaluation

Sponsored by
The Colorado Commission on the Status of Women
1525 Sherman, 600-C
Denver, Colorado 80203

Prepared by
Kathleen Blumhagen
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Ricki Martinez

May, 1977

TABLE OF CONTENTS

I. BACKGROUND

A. CCSW INTEREST

The Colorado Commission on the Status of Women (CCSW), a statutory body created by the Colorado legislature in 1972, is charged with improving the status of women in Colorado. The statute provides that the Commission shall include such activities as the following:

> Stimulate and encourage throughout the state the study of the status of women in the state...
> Recommend methods of overcoming discrimination against women in public and private employment...
> Promote more effective methods of enabling women to develop their skills, continue their education, and be retrained...
> Make surveys and appoint advisory committees in the fields of education, special services, labor laws, and employment policies, law enforcement, health and safety, new and expanded services, legal rights, family relations, volunteer services, and such other fields as may be appropriate...

During 1975, the Commission formally adopted employment, education, child care, and the Equal Rights Amendment as major goal areas for the fifty governor appointed Commissioners and two paid staff members that make up the Commission. In planning research and program activities around these goals, various policy statements were developed representing Commission concerns in these areas:

- -Equal pay for equal work
- -Employment alternatives within the job market
- -Alternative administrative practices in work scheduling and layoffs
- -Opportunity for upward mobility
- -Accessibility to all training programs
- -Full consideration of all job related experience, paid or volunteer
- -Utilization of women at all decision making levels
- -Fair representation of women in policy making positions of labor and management

-Job protection for lesbians
-Realistic consideration of an individual's ability to perform a job when establishing requirements
-Introduction and utilization of support services
-Elimination of sex-tracking and sex-stereotyping
-Consideration of minority women as women or as a minority and not one person who fills two requirements in an affirmative action program
-Fringe benefits of employment which do not discriminate and which are available proportionately to part-time employees
-Extension of basic workers' benefits and rights to groups of workers not now covered, such as household workers, agricultural workers, and homemakers[2]

B. APPLICATION FOR CETA FUNDS

The Commission learned that Governor-controlled discretionary or four percent funds were available through the federal block grant funds of the Comprehensive Employment and Training Act. An application was submitted and funding awarded in the spring of 1976 for a research project to build on the statutory directives and the goals and policies adopted by the Commission. The four research goals were as follows:

1. Evaluate present CETA programs in regard to quality of service, number of people served, impact, long-term effectiveness, etc.
2. Identify the specialized needs of women (particularly heads of households now dependent on state social service benefits).
3. Coordinate the support services offered by both governmental agencies.
4. Develop criteria to be used in evaluating future CETA proposals affecting the unemployed and underemployed woman.[3]

A research staff of a director, assistant director, and research assistant was hired in June of 1976 to conduct the twelve month study with a total budget of $46,030. The research contract specifies selecting six sites throughout the state, including the Denver area, for collection of data on the four research goals stated above. The

result of the study was to be a final report which could be used by organizations designing specialized programs for women and for upgrading existing programs which serve women. As mainly an issue identification report, it is an exploratory study on which more specialized studies can be built. It is one of only a few such studies since most CETA funding for women is used for direct services. (See appendix listing of these projects.)

C. COMPREHENSIVE EMPLOYMENT AND TRAINING ACT (CETA) AND ITS INTENT

> ...to provide job training and employment opportunities for economically disadvantaged, unemployed and underemployed persons, and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency by establishing a flexible and decentralized system of federal, state, and local programs[4]

CETA replaced various categorical programs funded under the Manpower Development and Training Act (MDTA) of 1962, the Economic Opportunity Act (EOA) of 1964, and the Emergency Employment Act (EEA) of 1971. CETA was to combine the programs funded under these laws, such as Job Opportunities in the Business Sector (JOBS), National Alliance of Businessmen (NAB), Community Action Programs(CAP), Neighborhood Youth Corps (NYC), Job Corps, and Public Employment Programs (PEP). By ending the categorical programs, it was hoped that local and state governmental units could assume a greater share in planning programs to suit the needs of their populations and that duplication between the various categorical programs could be ended. CETA was also passed in a political climate favoring revenue sharing programs and "block grants" and is one of several such laws creating such federal decentralization. For FY 77, there are nationally over 400 prime sponsors utilizing over two billion dollars in federal CETA aid.

The CETA law of 1973 as amened in 1974 by the Emergency Jobs and

Unemployment Assistance Act and in 1976 by the Emergency Jobs Program Extension Act has funds and programs under six titles, plus a definition section in Title VII. In most areas Title I funds the bulk of local CETA program activity for the economically disadvantaged,[5] underemployed, and unemployed population. It may include such activities as outreach, intake, assessment, classroom training, on-the-job (OJT) training, work experience (WE), and public service employment (PSE). Within the classroom training area, English as a Second Language (ESL), Adult Basic Education (ABE), and General Educational Development (GED) coursed as well as a classroom vocational training are program options.

Also included in Title I is the option to provide services to participants "which are needed to enable individuals to obtain or retain employment through the post-placement"...or to participate in other manpower program activities...leading to their placement in unsubsidized employment."[6] These services may include but are not limited to outreach, intake and assessment, orientation, counseling, job development, job placement, and transportation. In addition, supportive services may be paid from Title I funds in such areas as health care and medical services, child care, residential support, assistance in securing bonds, family planning services on a voluntary basis, and legal services.

Programs may also fund post placement services "as appropriate to terminated participants who have been placed in unsubsidized employment" with the stipulation that "these services shall be provided at the discretion of the prime sponsor and shall enable the terminated participant to retain employment" for up to a thirty day period

following termination.[7]

"Other manpower activities" may include services the prime sponsor may develop, such as "removal of artificial barriers to employment," job restructuring, revision or establishment of merit systems, and development and implementation of affirmative action programs. Title I activities generally consume the bulk of day-to-day CETA staff time.

Participants in Title I programs may be paid a basic allowance for their involvement in assessment, orientation, counseling, and training portions of CETA activity at a federal or state minimun wage hourly rate, whichever is higher, for each hour of participation. In addition, a weekly dependent's allowance may be made available at the rate of "$5.00 for each dependent over two up to a maximum of four additional dependents for a total maximum of $20.00 for six or more dependents."[8] For participants receiving public assistance, an incentive allowance of $30.00 a week is provided in place of the basic allowance. Allowances of any sort are reduced by the amount of any unemployment compensation being received.

Title II funds public service employment (PSE) positions with public or non-profit private organizations in areas of "substantial unemployment" or 6.5% or higher rate of unemployment within specified time intervals. Parts of A, B, and C relate to non-Indians and Part D relates to Indian tribes detailing specific aspects of Title II usage.

Title III funds special programs for Indians, and seasonal and migrant farm workers. Additional funds may be requested for "other special target groups" such as youth, offenders, older workers, those with limited English speaking ability, and women. A portion of these Title III funds are available for research, training, and evaluation

of CETA programs.

Title IV funds the Job Corps, which is administered throu h the federal Department of Labor and is available to local programs on a cost per participant basis. Job Corps included both residential and non-residential programs for low-income disadvantaged young men and women. Title V establishes a National Commission for Manpower Policy. Neither of these Titles' programs is a major part of local prime sponsor programs in the state.

Title VI, created through the two amendments to CETA cited earlier, adds funds for additional public service employment positions for the underemployed and unemployed in the areas of "excessively high unemployment." The latest amendment, signed by the President on October 1, 1976, is having regulations prepared and discussed, with funding still delayed in arriving to the local CETA programs.

For Title I programs, a political jurisdiction such as a city or county must have 100,000 people or more in order to qualify to be a "prime sponsor" or program planning and fund receiving unit. For receipt of other titles of CETA funds, the size of the political unit may be smaller and there are certain provisions allowing smaller units to receive Title I CETA funds as well. Indian prime sponsors have different population and regulations criteria for determination of prime sponsor status, resulting in some Indian tribes forming joint prime sponsorships together, others receiving their funds directly as their own prime sponsor, and others joining with an existing non-Indian prime sponsor for receipt of their CETA funds.

Before federal CETA funds are allocated to local areas, each prime sponsor must submit a comprehensive plan to show the "participation

in program planning of community based organizations and the population to be served."[9] The community participation is to occur through the creation of a Planning Council which is advisory to the political officials and the administrators of the prime sponsor program. The Councils are charged to "provide for objective evaluation of manpower and related programs operating in the prime sponsor's areas for the purpose of improving the utilization and coordination of the delivery of such services."[10] Planning Councils are usually appointed by the political officials of the prime sponsor and should include, "to the extent practical," members of the participant community, community based organizations, the Employment Service, educational and training agencies, business, organized labor, and agriculture where appropriate. The Planning Council, in consultation with staff and prime sponsor officials, determines the "significant segments of the population" in need of CETA services and often ranks these with percentages of the client population to be served in each segment. Before the plan is accepted by DOL and funds allocated, it is submitted to state and sub-state clearinghouses, such as regional and inter-county councils of government in Colorado, for comment. A summary of the plan is also published in local newspapers, usually in the Legal Section, soliciting public comment.

NOTES

1. Colorado law number, 24-35-201 CRS 73
2. Colorado Commission on the Status of Women meetings, 1975
3. Contract between the Department of Labor and Employment and the Commission on the Status of Women, page 5
4. Public Law 93-203, 93rd Congress, S. 1559, December 28, 1973, page 839
5. See glossary in appendix section of this report for CETA agency definition of these terms.
6. CETA Regulations, page 22
7. Ibid., page 23
8. Ibid., page 24
9. Ibid., page 14
10. Ibid., page 14

II. METHOD OF STUDY

A. FORMATION OF ADVISORY BOARD

An Advisory Board was formed during the early months of the study to oversee and advise the research project. (See Appendix). The 29 members were chosen to represent CETA staff and administrators, CETA clients, employers, state agencies, and community and Commission members. At its first meeting, the Board recommended that the research adopt a qualitative rather than quantitative orientation to the research. Following this orientation, the effort was to identify and analyze problems, but also to move beyond this to constructively offer program alternatives and recommendations to improve services to women. The CETA staff members of the Board said that many CETA programs realized they had problems serving women but they lacked alternative service models or approaches which they felt the research should address. The Board felt that the research should be a technical and objective study but that the staff should focus on the recommendations section.

B. SELECTION OF SITES FOR STUDY

The research contract specified that six research sites including Denver were to be studied. With consultation of the Advisory Board, selection criteria were developed as follows: geographic location, degree of emphasis on serving women, ethnic and racial groups served, and administrative model for the delivery of CETA services.

From the ten state prime sponsors[1], one of which is the Balance-of-State prime sponsor (which includes the geographic majority of the state and most of the sparsely populated areas of the rural and small territory of the state), the six sites chosen were as follows:

1. Larimer County--Small county with young program,

Administrative system of contracting all CETA client services to the local Employment Services offices. Anglo and small Chicano population.

2. Southern Ute Indian Reservation--Small Indian reservation served through Balance-of-State prime sponsor and administered locally by an Employment Service office . Indian population.

3. Grand Junction--Largest town in western Colorado though not large enough to be its own prime sponsor. Serviced through Balance-of-State prime sponsor. Anglo and small Chicano population. Co-location of ES, SER, and SUCAP in its delivery of CETA services.

4. Colorado Springs--Metropolitan area prime sponsor (city and county consortium) with extensive contracting pattern with local agencies in combination with strong centralized administration. Anglo, Chicano, and Black populations.

5. Denver Opportunities Industrialization Center--Sub-contractor under the Denver prime sponsor for Title I services, mainly in the area of classroom training. Predominately Black population.

6. Boulder--Prime sponsor program included a special Title III significant segments program on women. Services handled mostly in-house with a small contract to SER. Anglo and Chicano populations.

After completing these six research site studies, the Advisory Board authorized the staff to add a seventh site visit in order to have more complete data on programs providing non-traditional services to women:

7. Better Jobs for Women, Denver--A single agency funded nationally by CETA and not under any prime sponsor specializing in providing CETA funded services to women seeking jobs in skilled trades and crafts. Serves metropolitan Denver. Anglo, Chicano, Black, and Indian women.

Before making the final choices of sites for study, a Prime Sponsor Informational Survey was developed (see appendix). This was mailed to each prime sponsor during the month of July with followup meetings with Directors or senior staff of each prime sponsor during early August, 1976.

The survey assessed the sophistication of the management information system of each program and allowed staff the opportunity to visit sites and learn personally about the general features of each program. Comprehensive plans or other program documents were generally shared with staff at this time. This factual and impressionistic information aided in making research site choices.

Selection or lack of selection for study was not intended to mean endorsement of that program or its quality in any way. Rather, it was hoped that the site choices would represent, in addition to the stated criteria for choice, a spectrum of effectiveness and sensitivity to the needs of women clients in their areas in order to develop a realistic sense of the range of CETA services impacting women in the state.

C. DEVELOPMENT OF RESEARCH INSTRUMENTS[2]

Because the research staff generally had written documents on service, fiscal information, and client characteristics data, prior to their actual site visits, the site visit time was spent mainly in interviewing the three interest groups in the CETA system: staff, clients, and employers. Where possible, all staff members were interviewed who had any relationships to CETA services as well as several Advisory Board members.

In the case of clients and employers, a random sample technique was designed at each site in order to chose a sample for the approximately hour-long interviews. Clients also received a needs assessment interview immediately following their Client Interview, and staff were given the Support Services Survey immediately following their interviews, thus utilizing both groups as dual respondents.

With the prime sponsor staff interview, also used for Advisory

Board members, the effort was to get that staff members to discuss the program from their own perspective. The first question asked generally how people in the area learned about the program, their entry into it, and progress through it. Other questions asked for specific sorts of information in such areas as the planning process and the information or input used for it. The interview then turned to the staff person's sense of women's needs in the area, followed by an assessment of whether that program met these needs. Staff were then asked to describe any program evaluation systems in use and comment on the types of evaluation and contact that the program had from the regional Department of Labor. A strengths-weaknesses series of questions followed where the staff was asked to evaluate their programs as candidly as possible. The final question concerned that staff member's reactions to CETA as a concept and as presently being administered through federal and regional regulations and instructions to local programs. While each question did not specifically ask for information regarding the status of women, the underlying intent of the questions was to relate the provided information and opinion to women.

The client interview was primarily an instrument designed to establish the level of program involvement and then to follow each indicated program experience with evaluative questions. In this vein, clients were asked how they learned about the program and their reasons for coming to the program. After establishing the client's expectations, the sequence and duration of service were noted. Depending on which component the client experienced, individual questions followed to get feedback on the application, the type of introduction received, the level and type of counseling, the aptitude tests for courses or

further counseling, and the process of determining which program component they entered. Several questions querried whether the clients felt involved through the assessment and counseling stage and whether they felt that it was an individual choice of how to procede through the program and its options. Clients were asked about how much prior information they had about the program component in which they participated and whether they had learned and earned according to their own expectations. For terminated clients, information was obtained concerning their post-program status and specifically, whether they had located employment satisfactory to them as a result of their program involvements.

The Needs Assessment Interview asked for information regarding the respondent's employment history, including any present employment, with an analysis of any problems in the present or last job. Respondents were asked about their possible concerns with salary, working conditions and intrinsic aspects of the work itself, any benefits, hours, medical or legal needs, transportation, home situations with spouse and/or children and attitudes of their own or others toward their work as being a traditionally sex-typed job.

The Support Systems Survey was designed to ascertain the level and type of supportive service referral or service being provided by CETA or non-CETA programs in the area. It also established the level of staff information on these services. The particular five supportive service areas for study were: child care, transportation, medical needs, mental health and personal counseling needs, and legal needs. These were determined in consultation with the Advisory Board as being perhaps the five most important need areas for women.

Interviewees were then asked to think in ideal terms about the type of work, if any, that they felt they had the aptitude for and would truly most like to do. This was anticipated to be a difficult question for many clients who perhaps had never done this sort of thinking about themselves and their work potential. With the description of the ideal job, respondents were asked to detail the salary, work conditions, etc., they would like in their ideal job, using the same list of concerns discussed as problems in their present job. As a followup to the expressed ideal job, the client was asked to state what was needed to reach this goal, in such areas as education and training as well as supportive service needs for child care, transportation, etc. Clients were also asked to explore whether their ideal job required a particular economic or political setting and whether they would prefer to work in a flexitime, shared job, or other non-conventionally scheduled setting.

As a final area of interest, clients were asked to discuss the general situation of other women in the area particularly as this related to their efforts to obtain and maintain employment. As an open ended question, the respondents were expected to give a variety of different kinds of responses based on their own perspectives and experiences. It was also hoped that some of their own unexpressed concerns might be expressed in the more generalized discussion of other women in the area.

The final interview was designed for local employers, especially those involved as OJT, WE, or PSE employers who were presumed to have some involvement with the program. The interview was also used for unsubsidized employers where subsidized employment was not a part of

the CETA program. The level of involvement was determined in the early stages of the interview as well as information regarding how the employer had become involved with the CETA program. If contracts or financial agreements were held with the CETA program, these were discussed and information obtained about how the positions and/or training were defined and how people were selected to take part, Several questions then asked for the employers' sense of client needs, both for women and men, in areas that had influence on the work setting and whether these needs were being met by either that employer or by the CETA program and its staff.

The employer interview then moved to questions regarding affirmative action efforts of that organization and whether efforts to recruit more women were in effect especially in settings that were traditionally male jobs. Several additional questions gathered information on how the CETA referred individuals employed there had or were doing and whether any had been hired. From this discussion, the more general issue of assessing the effectiveness of the CETA program was raised and whether the success or failure of the CETA referred people was any reflection on the CETA program and its staff in any way.

Employers, in a series of closing questions, were asked how other employers might become involved in CETA related programs and whether their own particular organizations were interested in continuing their CETA involvements. Regardless of the responses to these two items, the final question asked for employers to suggest, in the general sense, how programs such as CETA could be more effective in working with people needing training and/or employment. This open ended question was intended to allow the employer to make creative suggestions about program emphasis and alternative approaches from the understood

perspective of an employer rather than as a human services agency staff person. It was anticipated that many new ideas might be gleaned from employers that would directly contribute to the planning of future CETA programs.

It was anticipated that data from these interviews would be tabulated and presented in discussion form on each site studied. The approach was intended to be documentary rather than judgmental of the views expressed by each group with a careful effort to tabulate general views as well as utilize exact language of the respondent whenever possible. Recommendations and any critical comments were planned for that portion of the final report based on all of the seven sites' data rather than doing this kind of analytical statement on the program at each location. Again, the intention of the research was to move beyond problem identification and on to program recommendations and presentation of alternatives which would be of use to program planners as well as interested members of the community.

NOTES

1. See glossary in appendix section of this report for CETA agency definitions of these terms.

2. See appendix for copies of the following interview instruments: Prime Sponsor interview, Support Systems Survey, Client interview, Needs Assessment, and Employers interview.

III. SITE VISITS AND DATA COLLECTION

While the organization of each site's presentation is similar, the items around which the discussion is organized vary by site. Unique features of each site required a slightly different form of presentation for each particular site.

III. SITE VISITS AND DATA COLLECTION

LARIMER COUNTY

A. OVERVIEW

The Larimer County CETA program has been in operation since the summer of 1975 and is newer than the other CETA programs included in the study. The administrative staff is also relatively new to the program. They are in the process of linking with Denver Manpower Administration for computerization of data and addressing other problems they have identified in the program. The data collected during this visit is reflective of the program then and the problems then identified may no longer be present.

Larimer County CETA was the site of the first in-depth study of the research. The prime sponsor is the Larimer County Board of County Commissioners. The administrative office is located in Fort Collins. The area served by Larimer County CETA encompasses six municipalities and has a total population of approximately 136,400, 70% urban and 29% rural. Colorado State University (CSU) is also located in Fort Collins and has a significant impact on employment in that area.

The approximate budget figures for each program operated by Larimer County CETA are:[1]

Title I	$447,691
Title II (PSE)	$373,146
Title VI (PSE)	$207,172[2]
Title III (Summer Youth)	$187,101
Governor's 4% Fund (Community Corrections)	$ 61,000

There are five persons on the CETA administration staff. Three CETA counselors are located in the Loveland ES office and four in the Fort Collins ES office. The ES representative in Greeley is employed

one quarter time by the Larimer County CETA program.

Each of the CETA counselors in the two ES offices is responsible exclusively for a specific type of activity. For instance, one counselor works with the WE participants and another works with the PSE participants.

Based on prime sponsor assessment of population and recommendations of the Planning Council four significant segments have been identified:

1. Economically Disadvantaged - because of Federal guidelines and CETA law.
2. Heads of Household - as primary wage earners in the family.
3. Spanish Surnamed - largest ethnic group in the city and have significantly greater unemployment rates and greater proportion of unskilled and underemployed persons.
4. Vietnam and Disabled Veterans - because they still have difficulty in the job market. 13% of applicants at ES are veterans.

Women, youth, older workers (45+), handicapped, ex-offenders, and other veterans are identified to receive priority status because all exhibit persistent difficulties entering or obtaining employment.

The enrollment goals are 80% for both economically disadvantaged and heads of household (included in the adult enrollment). The goal for the Spanish Surnamed is 35% and emphasis will be placed on the female Spanish Surnamed since their unemployment rate is 11%. The enrollment goal for Vietnam Era and disabled veterans is 15%. A monitoring process to keep appraised of female participation in each component, referrals to non-traditional training and jobs and equality in wages is also included in the comprehensive plan.

The major deliverer of services is the Colorado Division of Employment. They are responsible for the delivery of the typical services provided under Title I.

B. SELECTION OF SAMPLE

A random sample technique was used to select a client sample for study. From the total 796 clients served to date, thirteen were randomly chosen for the hour long interview. The client sample showed the following participation levels: seven classroom training, three Public Service Employees (PSE), one self placement, and one negative termination.

The same technique that was used to secure the client sample was used to gather a sample of nine employers who had been involved with CETA participants. An attempt was made to schedule interviews with all CETA personnel and 13 were actually interviewed. Planning Council and ES personnel were included in the staff interview sample.

C. ISSUES RAISED BY STAFF

In talking with the CETA administration staff two areas of concern were identified. First, because the staff was new to the program they were still in the process of learning how to administer it successfully. Secondly, the CETA counselors work in the local ES offices and there was a question of whether the counselors were responsible to the ES managers or to the CETA administration staff. The counselors were unsure how to proceed and did not know whose directives to follow.

1. Model for clients in program. When the staff was asked to describe a client's entry into and progress through the CETA program seven staff persons gave partial descriptions of common client experiences. Three other staff could only give an explanation of the particular program function in which they were involved, i.e. counselors knew only about the counseling component.

2. Planning process in the area. Six of the staff interviewed

did not know what the planning process was or were not involved in the planning at all. Three felt that planning was the responsibility of the administration staff. One of the three said, "They (the CETA administration staff) plan and tell the local office (ES) what to do." Only two staff thought that the Planning Council had any influence in formulation of program plans.

3. Identification of general needs of clients. In response to the question of how the general needs of clients were identified, eight of the staff interviewed felt that the administrative staff and the Planning Council determined the needs of clients. The Needs Assessment subcommittee of the Planning Council was mentioned by one of the staff persons as having the responsibility of client needs assessment.

Four other staff felt that needs identification was based on statistical information gathered from different sources such as Department of Labor, Employment Service reports, Prime Sponsor/Staff generated studies, and the latest census reports. One of these four commented that, "Statistics by themselves aren't very useful, they don't get at the needs of people."

The County Commissioners were described as a "bottleneck" which hampered the planning process and were said not to follow the recommendations of the Planning Council but sometimes "already decide before the Council is involved."

4. Needs of clients. When asked to identify the needs of clients eleven staff persons felt that child care was the most pressing problem of women clients. Child care in the area was described as "expensive" and as "a perpetual need." Child care for youth, those between the ages of six to twelve, was said to be unavailable. One staff person

said that women never express their need for child care to the staff.

Five staff saw Displaced Homemakers, usually without current skills and work experience, as having a great need for personal and vocational counseling. According to the observation of one staff person citing this need, "Women need awareness of what's available, their non-traditional thinking is limited."

Transportation was seen as "not too bad a problem" because it was viewed as "a community problem and not a CETA problem." This is a critical area because there is no bus service to Larimer Vocational Technical Center, the site for classroom training.

5. Ability of program to meet women's needs. Six of the staff felt the CETA program was partially meeting the needs of women. Some comments were that the staff "encourage clients to take care of their own needs if possible" and that there is "no crying need" for services.

These comments reflect the philosophy of some staff who believe that money should not be spent on supportive services and fail to see the relationship between the women's ability to be successful in the CETA program and having supportive service needs provided by CETA. In the words of one staff, "too much assistance is too easy for them."

Three staff felt the CETA program was successful in meeting the needs of clients.

6. Internal program evaluation. Next, the staff was asked for information concerning the internal evaluation of the program. Eleven staff indicated there was a regular internal evaluation of the program although they said there was "no real feedback."

7. Relationship between program and DOL and DOL evaluation. Seven staff members said that they had no personal knowledge of any relationship

between the program and DOL. Four felt that the relationship was helpful. The Federal Area Representative (FAR) seemed to be most important in the determination that the relationship was helpful. "Call the FAR if you have problems," was a frequent response to questions of how DOL figured in the CETA program.

DOL evaluation was spoken of by one of the staff as being, "too damn complicated and causing too much red tape." There were no responses supportive of the evaluation done by DOL.

8. Strong points of the program. There was little agreement of the strengths of the program as viewed by the staff. Every respondent seemed to have a different perception. Three staff felt that the connection with ES was an important feature of the program, but for different reasons. One reason was that the ES representative was said to be very effective in working with the staff and the Planning Council, another reason was that the working relationship between ES and CETA was seen as providing CETA access to ES files and employer contacts, and thirdly, because of the community acceptance of ES.

The administrative staff was viewed positively by three staff and described as "creative" and"responsive to the needs of participants."

Three additional comments focused on the Planning Council. Said one, "The Council is quick to recognize needs," and another said the Council is a "strong and helpful group." Still another shared the information that the Council has a practice of holding community meeting to give people an opportunity to have input into the program plan.

9. Weak points of the program. Five interviewees indicated that counseling needed improvement. One of the five said extensive training of counselors was necessary. The counselors in the program

are all located in the ES offices and there was evidence of some confusion as to whether or not these employees were responsible to the ES office or to CETA administrative staff. One counselor shared that he felt like an ES employee with "little knowledge of CETA functions."

The use of PSE positions was also in question. Most PSE contracts are written for six months and this was viewed by one staff person as being too short a period of time. This interviewee felt that PSE positions should be used to extend existing positions. Further, another said that PSE positions were just "using people for six months, with very little follow-up" on whether or not these positions resulted in permanent employment. Another calling PSE positions "a waste of taxpayers money," felt that since there is no obligation to pick-up clients emphasis should be on developing OJTs which have contractual obligations to hire. Another weakness cited was that classroom training is not used in conjunction with on the job training, whether PSE of OJT, to increase job possibilities.

Job development was said by one staff to be an area needing improvement. It was said that more time should be spent in the field contacting potential employers and conducting follow-up of those already placed in positions.

10. Comments on CETA. When asked if there were some additional comments concerning CETA and its application, one noted that there was a "need for provisions to be made allowing married couples of low income but above poverty level" to be included in the program.

CETA was seen by one as "too restrictive" and not giving "too many options," another holding the opposite view felt that the law was

very flexible leaving program implementation to local prime sponsors and delivery agents.

Dissatisfaction was expressed with "one set of guidelines for the whole country" by one staff member. Another questioned veteran's preference rules and felt that veterans should not be given priority finding this requirement "hard to swallow."

Concern was voiced over the definition of placement by the Department of Labor. Further, cost per placement of participants being used as criteria in evaluation of programs was viewed as inappropriate.

Finally, a staff member addressed the issue of how participants are defined as eligible for the program feeling that "hard core unemployed are not being served."

D. ISSUES RAISED BY EMPLOYERS

The data from employers indicated that while these employers were supportive of the CETA program, some were concerned with the commitment to hire citing their lack of funds for this purpose. Overall, they felt that the CETA staff should make greater efforts to explain the program to them and other potential employers to increase the effectiveness of the program.

1. Relationship with CETA programs. Eight of the nine employers interviewed had participants in PSE, OJT, and WE positions. The one remaining employer could not remember any CETA participant at that location.

2. Involvement with program. When asked how they became involved with the program seven employers said at the invitation of the prime sponsor. The other employers did not know.

3. Contractual agreements with CETA. In response to the question asking whether or not there was a contractual agreement with the program six employers indicated there was a contract in force. One employer said that he would "try to hire" CETA employees but that a direct requirement to hire was unrealistic.

4. Definition of positions. Responding to the question concerning defining positions filled by participants six said they defined the positions and terms of responsibility. Prime sponsors and employers were said to jointly define terms of responsibility and positions by employers at three other locations.

5. Selection of clients. When asked how clients were selected for employment, six employers said that they selected participants from those sent by the prime sponsor. One of the six said that there was "no involvement with screening of participants at the Employment Service office," adding that, "most referrals are OK."

6. Needs of women clients. The employers were next asked what they felt were the needs of women in the program. Six employers indicated that the women were most in need of skill training. Academic training (ABE,GED,ESL) and interpersonal communication skills were other areas cited by employers as needing improvement.

Two employers said that the women needed better work habits.

7. Are needs being met. When asked if the participants needs were being met and by whom; Employment Service, Virginia Neal Blue Women's Resource Center, and Colorado State University were named by five employers as responding to the needs of women. Four employers felt that the CETA staff was doing a good job of responding to the needs of women. Said one employer, "There is a need to orient local

supervisors to look for problem areas and refer these to the CETA staff for help."

8. More women employees involved. In response to the question of whether or not the employers were interested in employing more women, five employers indicated that the prime sponsor should locate more women for job placement.

One employer said he did not "see barriers to women anywhere in the system." He further stated that business "doesn't cater to any group."

Another said he would hesitate to hire women with the street department to drive big snowplows, adding that he would have "problems with conservative departments heads who wouldn't hire women." This was used as justification for not referring women to those types of jobs.

9. Affirmative Action Plan. When asked if they had AA plans for their locations two employers referred to the AA plan of CETA. Another employer said there was no plan but expressed a desire to hire "more Mexicans and Coloreds."

10. Increased involvement of other businesses. The next question asked employers dealt with their views on how business could become more involved with CETA. Seven employers thought that the prime sponsor should make CETA better known in the community and three said they would like to expand their involvement with the program. One of these three said his company "would want more OJTs," adding "it's better than welfare."

The selected employers are chosen by the program based partly on their ability to provide permanent employment to participants following

the agreed on term of placement, two employers said this "obligation to hire" was the reason they couldn't afford increased involvement with CETA.

11. Effectiveness of the CETA program. All employers interviewed expressed support for the CETA program. One of the employers said more funds and PSE positions should be made available through Title II.

Another felt that there should be more professional opportunities for PSEs and a third felt that the PSE positions should be used more extensively in the rural areas.

Another suggestion made by an employer was that CETA staff should maintain closer connections with other social service agencies in the area such as WIN.

Finally, sharing of program goals of the program with the employers was seen by one employer as a way to strengthen the program.

E. ISSUES RAISED BY CLIENTS

In general, clients seemed to feel their experiences in the program were beneficial. The information gathered indicated that there was lack of uniformity in services received and clients sometimes made choices based on less than complete explanations of what the program could provide.

1. How clients learned about CETA. In response to the question of how clients learned of CETA, seven clients learned of the program through another agency, usually the local ES office.

Five clients said they heard of the program from a friend, and one had heard of the program from a CETA staff person.

2. Why client went to CETA. When asked why they went to CETA eleven participants said they "wanted a job." Only one said she

wanted to go to school.

3. What happened to clients at CETA. No two clients had the same experience in the program. The answers of clients concerning their own experiences ranged from one client who didn't remember to clients who never saw a counselor to clients who were waiting for appointments and classes to open. One client, seeking classes in secretarial skills, after finding that there were none available at that time, secured a job on her own and never returned to the program for further services.

4. Written application. Responding to the question asking what they thought of the written application five indicated that they felt it was reasonable.

Two found the application "confusing" and "unreasonable," but one added, "as long as help is available for clients who have trouble (answering the questions) it's OK."

The reply of another client was, "If I didn't want to answer a question, I just didn't." This participant further stated that the counselor filled out the parts she left undone.

5. Introduction to CETA. When asked what the introduction to the program was like, seven saw their introduction as incomplete. One of the seven said that "more complete information should be given initially by the program staff," adding that , "this information shouldn't be limited to the indicated interest of the client."

Of five who viewed their introduction as having been complete, one said only after having been placed in a PSE position did she learn of other program options which she would have preferred.

6. Counseling. The next question asked was what counseling was like. Nine interviewees said they received counseling and five

of this number rated their counseling as helpful.

One woman suggested that counselors schedule free periods to allow participants time to talk with them as needed.

Two other suggestions were that job exploration should be included in counseling and that skill training and OJT placements should go hand in hand to provide a realistic view of occupations and job sites.

7. Aptitude tests. Participants were next asked what their feelings were about the aptitude tests. Only three women said they had had such tests.

One of the three felt the results of these tests should be used by clients to enable them to make interest choices and not by the counselors to steer the clients to a choice that the counselors thought best for them.

8. Decisions for placement. In response to the question of how decisions for placement of clients was made, seven participants felt that their decisions were their own with minimal influence from the counselor.

The response of two other participants was that their placement was the decision of the counselor.

According to the two other participants responding, a joint decision for placement was reached by them and their counselor.

9. Explanation of job and training. When asked if they felt they had complete knowledge of the program activity in which they were involved, seven participants said they had complete information.

The training was seen by one interviewee as a "great opportunity to learn long term needed things to help on the job."

All the clients enrolled in an activity said they had "learned" from the experience.

F. NEEDS OF WOMEN IN THE AREA

The women were, without exception, less than satisfied with their present positions. While income did not seem significant in choosing ideal positions, most rated their present income inadequate. The needs identified by these women, for the most part, were shared by all.

1. Job history. The first question dealt with present, past, or best job, what it paid and whether it was full or part time. The women interviewed a wide range of skills, jobs, and salaries from executive secretary to medical director of a major airline to part time babysitter. The salary range was from $336.00 to $767.00 a month.

2. Present job problems. The second question dealt with how the women felt about their present jobs. None considered her present job her best job. Inadequate salary was cited nine times as the reason for job dissatisfaction.

Even though inadequate salary was cited as an issue only one of the women interviewed was able to specify what she would need to maintain an economically secure existence. This one specified salary goal was for $12,000 a year.

The five women with young children all saw child care as a potential problem. Two of the five had married children who helped in emergency situations, such as when the children were sick. Others had arrangements with neighbors or relatives in town. These informal arrangements were an ongoing concern of these five women.

Transportation was another need identified by the women interviewed. One woman, speaking of her salary and need for transportation, said, "there is not enough salary to cover expenses of transportation."

Lack of benefits, primarily medical insurance, was identified as

an employment problem by five women.

3. Ideal jobs The next question asked women was what job would they choose, ideally, that they could do. One choice offered was not to work at all. None of the women chose this option.

Five women chose secretarial positions. These women felt this choice offered "security" and "benefits."

Other choices were clothing designer, business manager, social director for senior citizen's, Sheriff, and owner of a crafts shop.

4. How to get ideal job. When asked what they thought would be necessary to obtain their ideal jobs, nine women said they would need additional training and their present skills upgraded.

Financial and economic planning was seen as necessary by five women.

G. SUPPORTIVE SERVICES

There is a Larimer County Human Resources Directory that is available in all of the CETA offices. Three staff persons mentioned it as a source for needs referrals, although one staff perosn had "not found it useful." Another explained that they had such a book,"though it isn't often used." Others stated that the referrals are handled by the office with each having their own agency preference and the information is "in the heads of the staff." Further, it was stated by one of the staff that the plan does allow money for any supportive service needs.

1. Child Care: Four staff people refer child care needs to the Department of Social Services with one having "no idea of what happens" with those referrals and another saying this referral was only for AFDC and welfare clients. A fifth staff member made direct referrals to a list of day care homes and centers from Social Services explaining that "most clients make their own arrangements."

2. Transportation: Transportation is "not that hard usually," responded one staff person even though there is no public bus system in Fort Collins. Six staff persons said that bus tokens and allowances for clients in classroom training were available. Two staff said that attempts were made to place clients in jobs close to their homes or to facilitate formation of car pools. Hitchhiking and walking were suggested as alternatives to driving by one staff member. Another staff member said that CETA funds and loans from Social Services were available for minor car repairs. However, one felt that by meeting the needs of clients, "people are not taught self-sufficiency

3. Medical/Dental Needs: Referrals are usually made to Vocational Rehabilitation County Health Services or the Department of Social Services. One staff person said medicaid was used by AFDC clients.

4. Mental Health/Personal Counseling: Two staff persons said that they were available for personal counseling if , as one described it, "the clients need somebody to listen to them." According to one staff member, CETA has no money for these needs. Sliding scale arrangements are made with Larimer County Mental Health according to a staff person. Other agencies mentioned by staff members were VNB and CSU Counseling Center. The school district was said by a staff person to handle some psychological problems but additional information concerning costs or requirements for service were not known.

5. Legal Needs: "Haven't come across legal needs," replied one staff person, expressing the view that this was not a frequent need of clients. Legal Aid, Public Defender, juvenile probation court, and the Assistant District Attorney in Loveland were said to be avialable to clients by different interviewees. Another shared that staff personally

go to court with clients and always follow-up on these clients.

In the Larimer County Human Resources Directory, available for use in the ES offices, there are 30 listings for child care services in the area. There is a matrix included in this section that gives information on the various types of arrangements, financial plans, locations, numbers and ages of children to be served, an in many cases, includes transportation plans.

Transportation has five listings, some for specific services, such as emergency vehicles.

The services available for medical and dental needs are provided in the reference book with 17 listings. The services provided at CSU are available to students and their spouses only. There was not a listing for dental services in the health section. Some of the services dealt with special needs such as drug abuse and alcoholism.

Thirty-two listings are available in the section dealing with mental health and personal counseling.

There were only two listings for legal services; dissolution of marriage and legal aid. These services are only available at certain times during the week. Other agencies dealing with legal services do not provide general information to the public.

H. SUMMARY

The CETA administrative staff, while relatively new to the program, is a competent group, committed to making the program successful.

The major weakness in the program seems to be the result of having only one delivery agent, the local ES branches.

Some CETA counselors located in these offices were, instead of

carrying out CETA programs directives, working primarily as ES employees.

There was ongoing confusion concerning whether or not counselor supervision was the responsibility of the local ES managers or the CETA administrative staff.

Because of the location of Colorado State University in the area, the competition for jobs has the hard-core disadvantaged vying for jobs that are usually secured by college students and the spouses of some of the college staff.

The CETA administrative staff is aware that there are problems with the delivery system and are considering other options that may be more beneficial to the program.

NOTES

1. Figures taken from Budget Information provided by Larimer CETA staff.

2. Information provided by Bob Harden, Fiscal Unit, ETA of DOL Region VIII.

SOUTHERN UTE INDIAN RESERVATION

A. OVERVIEW

The Southern Ute Reservation is eligible for CETA funds under Titles II, III, and VI. It is administered federally through the Division of Indian and Native American Programs under the Department of Labor.[1] The funds for the Southern Ute Reservation are received through the Balance-of-State prime sponser, by formal request of the tribe, although the Indian programs are individually planned for and used mainly by the Indians themselves.

The tribal council with the assistance of the local Employment Service staff, Southern Ute Community Action Program, and the Bureau of Indian Affairs and key individuals employed by the tribe, plan for the use of CETA funds as a part of the overall development of the tribe.

The Southern Ute Tribal Council Chairman is a member of the Balance-of-State Manpower Planning Council for CETA and exchanges ideas for planning with the group.

The local Employment Service manager serves as the local administrator of the Southern Ute CETA program. In addition, the Southern Ute Community Action Program provides work experience programs under CETA.

Balance-of-State prime sponsor staff in Denver and in the regional Employment Service office in Grand Junction assist mainly in the receiving and dispersing of the funds to the tribe as well as in monitoring and providing technical assistance as requested.

The Colorado Indian CETA program is designed to "enable unemployed and underemployed Southern Ute Indians to acquire and

retain suitable employment and to assist in alleviating local labor and public service needs." The program hopes to contribute to the "necessary skills and motivation" needed to secure employment and reduce the "economic disadvantages that exist with the Southern Utes."

All PSE positions are defined by the tribe and its advisors. The tribal council "determines eligibility according to residency, unemployment, and selection relating to priority of service." In addition, the Council "actively recruits and selects people to fill the jobs." The tribe has developed its own policies and administrative and fiscal structures designed to operate the program for PSE employment.

The total budget for Titles II, III, and VI Southern Ute Indian and Ute Mountain Utes programs (which are handled jointly by the (Balance-of-State) for the period July 1, 1975 through January, 1977. was approximately $310,000. The allocation formula is different for Indian tribes. The total included $81,000 to create 86 summer jobs created for Indian youth.

Although the most frequent usage of the CETA funds has been for the creation of PSE jobs, lesser amounts are used to fund OJTs and occassionally to send students for vocational training to San Juan Vocational Technical School. Classroom training is a less popular usage of CETA funds because Bureau of Indian Affairs (BIA) funds are available to do educational training with more generous stipends than are provided through CETA. No funds can be awarded to any employer or subcontractor for the provision of supportive services.

The Southern Utes were selected for study after consultation with Balance-of-State (BOS) staff and local ES staff which serve

the reservation. The research staff visited the Southern Ute reservation between October 11-15, 1977. During the week, the research staff presented the research proposal before the Tribal Council and received approval for the task following questions concerning our purposes and general suggestions for our methods of study.

B. SELECTION OF SAMPLE

Client information was available from files on 61 past/present PSE, OJT, and WE Indian participants. Forty-seven Indian youth who had participated in the summer 1976 program were also identified. Essentially all of the clients had only post office box or general delivery addresses. In addition, 69 of the combined 108 group had no telephones and many of those whose files listed a telephone used a contact number of a relative or friend. The CETA staff did not allow the research staff to consult the client files directly and the research staff had to take notes while the local CETA staff read aloud from the files the pertinent information to determine participation and contact information.

In total, 11 clients were interviewed which included five WE participants, four PSEs and two others who received job counseling and placement services. The staff sample interviewed consisted of the two CETA staff; a manager and a secretary/intake technician, three professional staff at SUCAP, and the tribes Employment Assistance Officer. The employers interviewed were a representative of the tribe, the main employer, and a representative of the tribe's tourist center, the other major employer in the area.

C. ISSUES RAISED BY STAFF

The staff was concerned about the limited employment opportunities

available in the area due to the economics at that location. Another concern was the frustration resulting from having the program administered through BOS and feeling ignored by that agency.

1. Program model The staff was first asked about the program model. Two individuals had sufficient information to discuss the Indian programs at the state level and at the regional or national CETA level.

Two others had some information beyond the local area, but mostly understood the program only at the local level, with the two remaining staff knowing only what their particular job or office's part of the program did.

2. Planning process. In response to the question about the local planning process, two staff felt that state BOS staff did most of the planning for the tribe noting that "we get directions from Denver." Two others felt that the Tribal Council and the local ES staff really made most of the decisions. SUCAP, which provides WE on the western slope, uses local surveys for planning with input from a Board of Directors elected by the community, according to one staff person.

3. Identification of general needs of clients. When asked how the general needs of clients were identified, three staff indicated that the ES manager and the tribal employment assistance officer prepare ideas for the tribal council who "give help when help is needed." SUCAP utilizes its Advisory Board as well as local selection committees for planning and selection of participants for WE, observed two staff.

4. Needs of women clients. In terms of the needs of women in the area, four staff persons noted that women suffer from the lack of transportation.

Two staff observed that newly single women are a high need group among Indian women. Another felt that the older newly single woman faced the most serious prospects since they often lacked much formal education or job skill training.

One staff observed that Indian women who are mothers faced a slight job advantage since they were often regarded as trying to set a model for their children of "good discipline and self motivation" and were stable choices for employees.

In combination with a limited job market and a shortage of trained people in certain occupations, two noted that "communication skills" were a problem preventing stable employment for many Indians.

To take formal training and education for any sort of inside job, such as secretary work, represents a break in tradition and a start at different economic means of survival for many women, noted one Tribal Council member who gently reminded the research staff not to make judgement of Indian women based on outsider's standards.

5. Ability of program to meet women's needs. When asked whether or not the program was meeting the women's needs, three staff felt that essentially it was. As one staff person said addressing this question, "You gotta dance with who ya brung," meaning that they could only provide what was available. Three others thought the program was partially meeting the needs of women.

6. Internal program evaluation. In answer to the question about the internal evaluation of the program, one observed that "we have

local staff meetings," and "we keep records on clients," while another observed that, "occasional follow-up of clients occurs.

One summed up the situation as being one in which that was "no formal evaluation because everyone knows everyone and knows of any problems."

7. Relationship with DOL. Three of the staff indicated that they had no direct personal contact with regional or federal Department of Labor regarding their program. One volunteered that "BOS handles it" but thought that their program was well evaluated by the DOL staff. Another, who was unconcerned that contact with either the state or regional CETA was minimal, noted that whenever such staff was present "we tell them clearly what Indians want."

8. Strong points of the program. There were many responses to the question asking what were considered to be strong points of the program. Two felt that PSE jobs were highly important for both the tribe and the individuals who filled them. "CETA helps people who really want help and creates a situation of "Indian people helping Indian people," observed another staff person. Another staff person noted that PSE jobs pull the local wage scale way up and offers good jobs with year around work and fairly good future prospects.

9. Weak points of the program. When asked what the weak points of the program were, the most prevalent concern of all six staff was the unpredicatability of funds and directions from the BOS staff at the state level. There is a "lack of direction" from the state level, observed another, leading to situations where Indians are given short periods of time -such as a week - to develop plans for CETA dollars.

The irregular arrival of funds led to disorganization and to program disruption, according to one staff person . Two other staff indicated that the disorganization results in frequent and unnecessary modifications of the funds, especially the shifting of funds between titles which could have been avoided. But "Indians always get put on the back burner," and have thus far been "too patient" rather than protesting the situation to the Governor or other highly placed individual, " observed one.

Other program weaknesses concerned the insufficient number of jobs and one staff person said that those with skills that cannot be used in the area should be encouraged to relocate rather than be unemployed.

10. Comments on CETA. Staff persons were next asked to make any comments they felt were necessary concerning CETA. Concerning the law itself, three expressed hope that the regulations could be modified to allow for more local designation of "disadvantaged" rather than having local areas being given a federal definition of disadvantaged in terms of cash income.

With income cutoffs for portions of the CETA program, one observed that the temptation is to "fudge" and declare one's income within the allowable maximun whether it is there or not, in order to qualify for services.

Another staff complained that it was too restrictive to have to be unemployed and disadvantaged for certain categories of PSEs but only unemployed for others, especially with the frequent need to shift funds between different titles following BOS modifications.

One staff person thought that CETA funds always had "strings attached," such as the two year limit for funding and involvement with a client, the unavailability of CETA funds for training out of state or even at other than the local training institutions.

CETA stipends were said to be insufficient for survival, by one staff person who went on to say, that this makes the tribe's present trend of using CETA funds mainly for the creation of PSE jobs the only viable way to improve the economic condition of the tribal members' lives.

D. ISSUES RAISED BY EMPLOYERS

The employment situation at this location was unique to the study. The Southern Ute tribe provides the employment base for the reservation and while they wish to be in control of their own economic future, they realize that at the present time they can offer only limited employment opportunities for those they serve.

1. Relationship with the program. The first question dealt with the relationship of the employers with the program. Both of the employers had experience with mainly PSE types of CETA participants, although both had work experience students during the summer. Both of the employers interviewed are involved in CETA through their work as tribal employees at supervisory levels.

2. Definitions of positions and responsibilities. In response to the question of how positions and responsibilities are defined, the following explanation was offered by one of the employers:

PSE positions are designed by the tribe after notification is received from BOS concerning the amount of CETA funds available.

When this information is received the tribe's Employment Assistance officer, the ES manager and the Tribe's executive council meet to "brain storm" ideas. The Chairman of the Tribal Council is then consulted, followed by presentation to the entire Council. Job titles, salaries, and responsibilities are then determined by the tribe's personnel system.

3. Selection of clients as employees. In response to the next question asking about the selection of employees, one staff person said that candidates for positions are first screened by the ES manager and the tribal Employment Assistance officer with the Tribal Council having the final selection authority.

4. General needs of clients. When asked what the general needs of clients were, both respondents felt that basic education and skills training were needs of the people served, although both felt that there were ample opportunities provided to answer this need through CETA and BIA.

The two employers also felt that communication skills were particularly deficient among many Indians; both in writing and in personal oral communication.

Both said that efforts to continue work with alcoholics and other problem drinkers were needed.

Finally, one employer noted that there was serious overall poverty on the reservation, with better income through better paying jobs being high on most people's needs.

5. Are needs being met. The next question asked whether these needs were being met. Both of the employers felt that most of the

needs of clients were being met. The PSE positions themselves were creating additional income for the tribal members so that CETA was helping with these needs.

6. Greater women employee involvement. Neither of the employers felt that the tribe had any problems with equal access to jobs on the basis of sex. It was noted that women work as Associate Judges, police dispatchers, maintaneance workers, janitors, radio managers, and heads of major tribal offices in education, economic development, and HEW tribal services, many which are PSE jobs.

7. Success of participants. When asked about the success of the participants, one employer noted that 85-90% of the PSEs are "absorbed" by the tribe and this employer could only recall one person that had quit a PSE position.

8. Increased involvement of other businesses. Next, the employers were asked their views on other businesses becoming involved with the program. Neither of the employers was optomistic concerning this prospect. Most of the other businesses were said to be family owned, providing few job openings for non-family people.

Both supported the tribe's efforts to bring in new businesses which would provide employment opportunities.

9. Other ideas concerning the program. In response to the question asking for other ideas concerning the program, one employer felt that the criteria for determination of disadvantaged should not be income alone, or should be above the present level. Many families on the reservation are not eligible because they are just above the cutoff level even though they are poor.

Another idea shared by one of the employers was that CETA

needs to continue its efforts to subsidize or create year-round jobs because many of the jobs on the reservation are seasonal.

Training opportunities under CETA need to take a different approach, suggested both employers, and greater efforts need to be made to bring contractors to the reservation who will hire Indians in apprenticeship positions and give them the required training.

Both employers recognized that the tribe was just beginning to economically develop and that some of the disappointments were perhaps inevitable. Yet, both expressed hope that CETA funds and programs might contribute to the smooth economic development of the tribe and felt that a good start had already been made.

E. ISSUES RAISED BY CLIENTS

The clients all knew what to expect of the program because of the smallness of the town and the close-knittness of the tribe. They were all knowledgeable of what opportunities were available and had a realistic view of what the program could provide.

1. How clients learned of the program. The clients were first asked how they learned of the program. As two clients put it, it is "common knowledge" in Ignacio that there is a CETA program and one either goes through the tribe or the Employment Office to get information and seek participation. This summed it up for most of the clients. Six clients who indicated that a friend told them, said that that friend was either the ES manager or the tribe's Employment Assistance Officer.

2. Why clients went to the program. In answer to the question of why they went to the program, several clients volunteered that they had been involved with both CETA and its predecessor program, MDTA,

indicating that they had knowledge of what the program could provide.

3. Written application. When clients were asked what they thought of the written application, there was a mixed response. Four of the clients felt that it was a fairly standard type of application and had no difficulty filling it out. One felt that being asked about her parent's income was unfair since she was not being supported by them. Two could not remember filling out an application and two others had not been able to declare their family income and had to return a second time, after consulting their other family members, to complete the application.

4. Introduction to the program. The next question asked about the client's introduction to the program. Four of the eleven clients felt that they had had an inadequate or non-existent orientation to CETA and CETA programs before being actively enrolled.

Two had information only about the particular PSE jobs they had applied for and did not know about any other features of the program.

The other seven felt that they understood enough about the type of program they were entering.

5. Counseling. In response to the question concerning counseling, six felt that some personal exploration had occurred with a CETA staff person and felt helped as a result. Three felt that they had talked with staff only long enough to be interviewed for a specific job and three others indicated that most of their counseling had take place in a group setting but that they could have had individual sessions if they had asked for them. Three more clients

observed that their whole conversations with CETA staff concerned what kind of secretarial job they would like and had the qualifications for. Two of these last three were very dissatisfied with this type of counseling. One client felt that having only one professional CETA person in the ES office was a disadvantage since no one person could hope to be the type of counselor that every type of client would want or need.

6. Aptitude tests. Nine of the eleven clients had not taken any aptitude test. One woman said she had taken a test "long ago" but did not remember if she had ever discussed the results with a staff person.

7. Decisions for placement. When asked how the decisions for placement had been made, the clients all felt that they had the most choice in the type of involvement they had with the program. While seven participants felt that they had chosen the type of involvement they had and four indicated that their involvement reflected the availability of jobs at the particular time they came to the program, several clients said that the choice of jobs available under CETA were always limited.

8. Explanation of training. The next question dealt with whether the clients felt that they had an explanation of their training before they started it. All of the clients, except two WE participants, said they had adequate information about their CETA training or job before beginning it although some indicated that the entire enrollment process was "really informal" and could not recall having read or signed a contract or other formal papers. The two WE clients felt that orientation needed to be

more extensive to make it clear that work was expected in return for money paid. The two WE were youth workers.

9. Clients feelings about the program. In response to the question asking for clients feelings about the program, nine of the eleven clients felt very positive about their experiences in the program and one felt negative about the worth of her involvement. One person was still being counseled on a regular basis and had not completed a program segment. This woman felt that she should reserve judgement until she had been placed. A woman in sharing her feelings about her program experience said that she had learned a new faith in her own ability but feared leaving the employment with the tribe and seeking work elsewhere.

There were complaints. One client felt that not much was learned in the assigned OJT position because of the supervisor/teacher's lack of skill in the trade involved.

Another woman felt that women got less pay than men on the tribal payroll and hoped that the research staff would do a wage study of the entire payroll.

10. Job success after program involvement. The five clients who had taken jobs other than their PSE of WE jobs were making between $1.25/hour plus tips (waitress) to $3.20/hour (finance office worker). One high school graduate had hoped that her WE would extend past summer but it did not because funds were not available. Two other clients returned to school and the three remaining clients in the group were still in their PSE jobs hoping to be absorbed by the tribal payroll when the CETA funding ended.

F. NEEDS OF WOMEN IN THE AREA

Even though these women were in a different setting than the other women included in the study, and seemed to have the support of the tribe, child care and transportation were still problems for them. This supports the notion that all women share many of the same needs.

1. Job history. The best paying job was held by a woman who was presently earning $7100/year. For several others, the best paying job was the WE job they held which paid minimum wage, $2.30/hr. For all but two, the best paying job was also the favorite job. Not suprisingly, six of the 11 felt that the main problem with their present or last job was its low salary. Most of the jobs held by this group did not have any fringe benefits except for those who had worked for some lengthy period of time.

2. Present job problems. Four felt their jobs were inadequate. Another felt that she had "enough responsibility for now" but very much wanted additional responsibility as soon as she felt that she had the experience. Others had specific grievances against their present positions, such as unfair supervisor, insufficient light, and poor security for late night work. One individual genuinely preferred to be doing a different job but felt that a committment to the tribe came before personal preference. Another person was very concerned that "jobs with the tribe have no future" with work that was not sufficiently challenging and little opportunity for advancement. Given the size of the tribe's population, the respondent felt that little could be done about this, but felt that it was a situation that might lead young ambitious Southern Utes to leave the reservation for opportunities elsewhere.

Other concerns voiced were two who felt that irregular work hours interfered with their family lives, while two had regular difficulty arranging transportation to work since they did not own or have access to autos. Several women indicated that their husbands were unhappy that they worked, creating ongoing dissension in the home. Additional concern was added by two women whose family members took care of their children while they worked because they were not satisfied with the level of care provided at the tribally owned and run day care center. Two had health conditions which occasionally interfered with their work situations, although neither had shared the exact nature of their chronic medical problems with their employers or supervisors for fear of losing their jobs. Instead, each had the regular care of the Indian Public Health Clinic located near their places of employment, minimizing their need for extensive time off to seek medical care.

3. Ideal jobs. One woman said her ideal job would be doing the same job she presently had. Two were unsure of their ideal job choices. Two desired to be athletic or recreation directors or teachers.

Outside labor, such as carpentry, was the ideal job choice of two others, while another young woman wanted a career in electronics. Another woman wanted to be either a jet pilot or a fire jumper but only knew of women doing the latter job. She was disappointed and observed, "I don't know of any women jet pilots."

Another woman expressed her motivation to enter non-traditional employment simply because "men's jobs pay better than women's."

Other women were less specific about their ideal jobs but wanted something "outside" or "in my own company" or something that would "contribute to the tribe" and provide her enough flexibility to meet her own children as they returned from school.

4. How to get the ideal job. Eight women felt that the route to ideal jobs lay in additional training or education of some kin , varying from bachelors degrees to specific apprenticeship or vocational training.

Three of the women indicated that throughout any such effort to secure ideal jobs, a consistent and quality arrangement for child care would have to be provided and another three women said that without financial assistance, none of their plans could be realized.

An older woman felt that age discrimination would be her biggest barrier both during training and in seeking a job while, a younger woman felt that her youth and lack of experience would be her biggest barrier.

A dramatic change in the attitude of a husband was necessary for one woman before she could pursue an ideal job.

5. Employment needs of other women in the area. The most serious need of both men and women noted by five was for sufficient jobs with opportunity. "This town's too little," concluded one of the respondents.

Two others felt that efforts for alcoholism treatment needed to be continued since this problem prevents or interfers with many jobs.

Three interviewees viewed the older woman as being particularly disadvantaged, often lacking training and skills as well as the confidence to seek a job. "Most stay home and suffer," said one woman.

"Some jobs you get by default around here because nobody else wants them," observed one , suggesting that more recruitment was needed.

G. SUPPORTIVE SERVICES IN AREA

Although there was apparently no prepared book of supportive services for staff use, each staff member had frequent experience making referrals except for one WE staff member who indicated that "for WE we don't do many referrals." The other five provided the following information regarding supportive services in the area, which they believed to be commonly known by members of the tribe:

1. Child Care: Four of the five made regular referral to the Southern Ute Children's Center for clients needing child care. For certain income categories, staff explained the fee is $1.25/week and the facility is generally filled. During a research staff tour of the facility, child care center employees pointed out that there is not sufficient space or available staff for the very youngest babies and that they cannot accommodate the complete needs of the community. They explained that with older pre-school aged children, additional staff with Head Start program make increased enrollments possible and there generally is not a problem in arranging space for this age group.

2. Transportation: Since there is not public transportation system in the area, people generally rely on cars, whether one's own or a friend's. Three staff indicated that they encourage car pooling and that according to one respondent, an interested person simply contacted the ES manager "to fix up a system." Two pointed out that SUCAP had several vans for program use but that they were generally only available for emergency use or special program activities. SUCAP staff informed research staff that they have been working with Region 8 Council of Governments to plan for a public transportation system for some date in the future.

3. Medical/Dental: Four of the five respondents made regular referrals to the Ignacio Public Health Service Clinic which one proudly

noted has "one Ute nurse." Three made reference to the availability of the Southern Ute owned ambulance operated by the Ignacio Volunteer Emergency Squad, available to both Indians and non-Indians. The Durango public hospital, noted two, has a contracted arrangement with the reservation for long-term medical care of Indians.

4. Mental Health: Four staff made regular referrals to the Southern Ute Alcoholism Program and Center, the Peaceful Spirit. Two sent clients to the Southwest Mental Health Center in Durango while two others suggested that their clients make appointments with a psychiatrist who had office hours once a month in the tribal community center in Ignacio. The tribes's social worker and the staff in the Head Start program do counseling, noted two, and the Ignacio sheltered workshop staff are also involved in some counseling. Although they mainly do vocational counseling, the ES manager and the tribal Employment Assistance Officer were also credited as doing some personal counseling with clients as their time permitted.

5. Legal: Although the tribe has a part-time lawyer, his services are mainly for business involving the entire tribe rather than legal problems of individuals or families. For this latter purpose, two staff directed clients to the Rural Legal Services office in Durango which serves people in a sliding scale fee system. One respondent explained that there were no Southern Ute lawyers but that a Southern Ute young man was nearing completion of law school and was expressing interest in returning to the reservation to practice law.

Other resources available to residents of Southwestern Colorado are listed in the Colorado Women's Resource Book by Marilyn Auer and Constance Shaw. These include offices of Planned Parenthood in both Durango and Pagosa Springs for counseling and gynecological services.

In addition, both towns have county offices of the Department of Social Services which license and list day care homes and centers in each county in addition to other regular services. There is an Office of Human Resources and a new VNB Resource Center for Women in Durango, which might also be of assistance to tribal members.

The Social Services Office of the tribe and the SUCAP provide or coordinate additional supportive services. Besides the services mentioned by staff, there is medical transportation provided through the Community Health Representatives of the Ignacio Public Health Service. Medicare and Medicaid services are available in the Ignacio area. Housing, nutrition, and services to the aging are also furnished through the tribe or SUCAP.

H. SUMMARY

Limited employment opportunities in the area is a concern of the Southern Ute administrative staff. One way that the tribe has tried to compensate for this situation has been in their use of CETA funds for PSE positions. The positions are created where they will be of most benefit to both the participant and the tribe. Many of these positions are in the tribal governmental office.

There have been efforts to get more private companies to locate their business in the area. At present, contracts are under negotiation for the development of oil and gas resources with private companies where economic development and job creation can occur while still allowing the tribe to maintain controlling interest and authority over the use of tribal lands.

Another concern has been that funds from BOS have been received on an irregular basis hampering the ability of the tribe to make both long and short range plans. One solution offered to BOS by the tribe

was the possibility of making two year contracts with the program, freeing staff time on both ends to carry out programs rather than almost continually to be writing grants for the next year's program.

Many clients were caught in the dilemma of whether or not to remain on the reservation where there are limited opportunities or to leave and seek opportunities somewhere else. Because of feelings of loyalty to the tribe, this was a very difficult choice for some of those interviewed.

There are funds available from the Bureau of Indian Affairs to provide some services, such as training grants, that are not available with CETA funds.

Overall, the tribe is aware of the problems they face and seem to be in the process of seeking solutions.

NOTES

1. Taken from grant applications and statement of work contracts for the Indian programs for the fiscal years '75 through '77 on file with BOS staff in Denver. See Grand Junction for a further explanation of BOS.

GRAND JUNCTION

A. OVERVIEW

The Balance-of-State CETA program is comprised of the 54 counties not included in the nine CETA programs operating at the city and county levels elsewhere in the state.[1] Administratively the Governor is the titular head of the BOS CETA program and has designated the Training Services Section of the Division of Employment and Training, Department of Labor and Employment, as the state administrative unit to plan and execute BOS CETA services.

Title I funds for BOS, which for FY 77 are in the annual range of $2.5 million, are projected to provide services and training resulting in placement in unsubsidized jobs for 1128 (65%) of the 1748 individuals participating in the Title I CETA program. Projections of the significant segments of the population to be served are as follows:

Heads of households	50%	Older workers	10%
Special veterans	15%	Females	50%
Other veterans	10%	Migrant/Seasonal farm workers	10%
Spanish surnamed	30%	Native Americans	5%
Youth	25%		

Title II funds, which to date have totalled just over $1.5 million, are used to create PSE positions for approximately 200 participants a year to 30 of the 54 BOS counties designated as "areas of substantial unemployment." Priorities for participation are as follows: handicapped veterans, special veterans (service after August, 1964), previous CETA trainees, welfare recipients, and others who are unemployed.

Title III funds are used to operate a Summer Youth program, with a total amount received to date of just over $2 million.

While PSE positions are created by Title VI funds as well as Title II, the eligibility requirements are different in BOS. The roughly $3 million expended thus far under Title VI has been used to create "standard non-transitional job opportunties with public agencies, non-profit organizations, and local governmental units." The significant segments to be served are 54% heads of households, 20% veterans, 30% Spanish surnamed, and 50% females.

The CETA program in Grand Junction was chosen from the BOS area because the four contractors all conduct their programs in the same office and could thus be jointly studied there: ES, SER, VNB, and SUCAP. At the time of the study, October 25-29, 1976, the CETA staff of the ES numbered two, with one SER representative and one VNB representative forming a four person working team to deliver CETA services. Another CETA paid VNB staff member conducted CETA activities at another location, the Women's Resource Center. The SUCAP representative handled WE for the Grand Junction area as well as several other counties and was not involved directly in the delivery of the non-WE related services.

Grand Junction is also the location of area offices of the ES and SER and representatives of each of these two office along with the local ES office manager were interviewed as a part of the research.

Grand Junction is the largest city in Mesa County, a western slope county bordering on Utah along its western boundary. Mesa County is slightly better off than many BOS counties, with only 11.7% of the population of public assistance and 11.4% living at or below the poverty level. Its 4.1% unemployment rate is only slightly

above that of the state and its population of approximately 60,000 is 89% Anglo, 9.7% Spanish surnamed, and 1.3% others.

Grand Junction is the largest city in the BOS and it serves as a commercial and transportation center for the surrounding farming and ranching population of western Colorado. In contrast to the mostly urban locations of most of the reserach sites, Grand Junction offered an example of CETA services in a smaller town and rural setting with four different contractor organizations jointly providing CETA services at the same location.

B. SELECTION OF SAMPLE FOR INTERVIEWS

A random sample technique was used to select the client and employer sample at this site as in the others. From the files of clients and employers, a total of 15 clients (11 PSE's, 3 OJT's, and 1 WE) were contacted for interviews. Six local employers, three of whom were involved in OJT and three in PSE contracts, were interviewed. A seventh interview, an OJT employer, did not keep his appointment and did not answer a note left at his desk. Clients with files in the direct placement area or marked "OE" (obtained employment on their own) were not included because it was assumed that their knowledge of the CETA program would be minimal.

In addition, 10 staff, representing the ES area and local office managerial staff as well as the BOS level staff, local CETA staff of the ES, area and local SER staff, VNB staff, and SUCAP staff were interviewed. One Advisory Council member was interviewed using an abbreviated interview. Data from this interview will be incorporated into interpretive remarks on the tabulated data from the other interviews.

This client group, while disproportionately PSE's, resulted from a total pull of 23 client names from active and recently terminated client files. Of those not located for interviews, four were OJT's no longer at that job or home address with no phone number listed locally. Three other OJT's were no longer at their jobs but had home telephone numbers, although staff could not reach them after repeated calls to their homes during day and evening hours. The other two clients, both direct placements, were not at their home phones during day and evening calls. The other two clients, both direct placements, were not at their home phones during day and evening calls. On the other hand, locating PSE clients proved to be quite simple since all but one of those in the client pull were still at the same address and phone as shown in their files. This was not the case with the non-PSE sample, most of whom were Title I low-income participants whose lives were not as stable in terms of having permanent addresses or phones.

C. ISSUES RAISED BY STAFF

Grand Junction was a site where the staff was all working for CETA but represented different organizations, such as SER or VNB They were all also working at the ES office in most cases, meaning that the staff had responsibilities to ES, to CETA, and to their parent organization.

1. Model for clients in program. The staff as a group were functioning with varied levels of information regarding the CETA program for the BOS. On the first question, which asked for an overview of the model for client entry and progress through the system, six could discuss this issue with some degree of thoroughness,

while two could discuss only what happened to clients involved with their own particular component. Few staff volunteered descriptions of how the various contractors under BOS were to coordinate their services together and usually each staff member described the CETA program from the perspective of their own home agency.

2. Planning process in area. When asked to explain the planning process for the Grand Junction area program, the most frequent answer (4), was that the staff "did what the area office said," as one respondent put it. Another offered that " Schatz (one senior staff member at BOS) made most of the decisions," and then these were given to local offices for delivery in essentially direction form. Three had no idea who made decisions and why the program was run as it was, with one feeling that the area planning council had some part in sharing decision making with staff. However, this person declared the council is "not functional" in the decision making process, a view that was shared by the planning council member interviewed.

One senior staff member indicated that "we have no planning process as such," and that "things get arbitrary," and "stereotyped planning occurs." He said this was because CETA regulations and instruction dictated certain groups for service, taking away from the decision making process of prime sponsors. Also, the BOS geographic area is so diverse that planning for a particular program location is difficult even with the best of intentions and data.

3. Identification of needs of clients. In responding to questions regarding how clients's needs were determined to design the program, the question caused confusion among many of the interviewees. Three staff members did not know how client's needs were determined

and three others felt that decision makers, whom they could not identify, were presumed to use some kind of data or knowledge about clients but they did not know what it was.

4. Needs of women. Answers were varied on the question of specifying the needs of women clients in the area. The most frequent answer to this open-ended question was that women needed more education and training (6), but several qualified their answers with such comments as, "but we're not in the business of doing GED."

Half of the responding group felt that displaced homemakers and women heads of households had special needs that CETA programs might need to address, but the enthusiasm for serving this group was not uniform. "They're a problem," declared one, and "older women over-react and panic in general," offered another.

Half of the respondents listed higher incomes and better paying jobs as the most pressing problems facing women in the area. Another half of the interviewees felt this problem would not be impacted until sex stereotypes concerning jobs, presumed gender related ablities, and employers' notions of sex appropriate jobs were broken down and women had access to training and placement in better jobs. Noted one, women need to overcome their own "severe resistance" to non-traditional jobs which the staff member attributed to the "defined role structure of rural Colorado." "The clients aren't ready for non-traditional jobs," and the "community is not committed to equality," explained two staff.

Four observed that many women need extensive counseling of both a personal and career planning nature especially for those women who are newly heads of households, whatever their employment history.

Four staff members mentioned child care as a need although one noted the shortage of child care centers which he attributed to a prevailing view that "it's not profitable to have centers in BOS." Transportation was noted by four as a regularly occurring supportive service need.

5. Ability of program to meet women's needs. Two staff members felt that the program was meeting women's needs. The others felt that there were some or many areas of need which were not being met by the program.

6. Internal Program evaluation. When asked about the existence of any regular internal evaluation system for assessing the effectiveness of program and staff, one staff stated that there was no formal system in operation. The other staff described the regular process of area supervisors and occasionally state BOS staff coming to inspect records, introduce new record-keeping systems, and give direction for corrective action where needed.

7. Relationship between program and DOL. The relationship of the Grand Junction program to CETA in general and the regional DOL in particular were largely unknown to seven staff members. "We just follow the rules" and "send in reports," explained two of this group.

The general sense of seven of the staff was that any degree of relationship to the CETA and DOL bureaucracy was handled mainly at the regional ES-SER level, where such staff were viewed by one in this group as "record keepers and monitors." Most of the staff members seemed to feel unrelated to the larger CETA system beyond their local area involvement.

Two respondents did have evaluative comments on DOL. One noted a positive relationship with the present and recent past FAR's. The other felt the relationship with DOL was problematic because DOL was in the midst of its own "evolution--of weaning itself from control of local programs," which occurred during the MDTA days prior to CETA. This staff member explained that "we use DOL because we're so far behind the other prime sponsors in our sophistication."

9. Strong Points of program. The responses to the question asking for program strengths varied, with only one or two respondents answering any particular item. The features mentioned included strong OJT and PSE programs, increasingly good job development , the value of the special workshops for women sponsored by VNB, and the fact that the program had essentially met or exceeded program placement goals in every category. Several noted that the staff worked well together and that it was an advantage to have the various agencies working together to deliver CETA services. The arrangement, noted one, allowed staff to be more "on their own," since this person felt that, "in the ES, someone is always looking down your back."

10. Weak points in program. After this positive information, responses concerning program weaknesses were given. Again, only one or two people gave any particular response. The general feeling of several was that area and state offices were "too interested in numbers and not enough in serving people."

Several felt that state BOS staff were a confusing group: "I never know who works there anymore; it changes so frequently," and "the good people keep leaving." One asked the interviewee to "tell the Governor how bad things really are," which another concluded was

due to a "lack of leadership at the top levels.

One person felt there was too much duplication of effort in BOS, citing dual ES and SER regional staff as an example. Another person felt the state administrator for CETA should do only this, instead of also administering several departments as is now the case.

The allocation of CETA funding in the BOS was mentioned by five as being problematic. The most frequent concern of this group was that there was no advance planning but that , in the words of one, there was "a regular game of catchup" when monies arrived from the BOS level. This resulted in hastily drawn up plans for service rather than a deliberate delivery system with carefully planned components.

Other problem areas noted were more specific to the local office in Grand Junction. Several staff noted that stereotyped counseling occurred in working with women, resulting in a routing of women toward traditional training and job placements. One person noted that the staff in general was "mediocre with little social awareness of women and minorities."

The co-location of the various CETA agencies together in the ES office seemed to foster some competition between agencies concerning which would get the credit for placement of a client when staff from several agencies may have assisted that client in some form, according to several staff members. With the co-location, the practice of requiring program staff to carry a portion of regular ES traffic was resented by three as being an inappropriate use of CETA staff time.

Several staff members indicated that in order to assist disadvantaged clients to successfully compete for jobs, there needed to be less emphasis on "early placement" and more emphasis on employability

development planning. Several confided that a plan for employment is often done on paper level only and well after a client is no longer actively involved in the CETA program.

11. Comments on CETA law. Most respondents had difficulty commenting on CETA as a law and whether the present regulations were satisfactory, presumably because of a lack of information in this area. Most were unable to distinguish among the CETA law, the federal regulations written for the law, and the various BOS level stipulations. Three felt all three were satisfactory and had no comments. Two long-term staff liked CETA's predecessor law, MDTA, better than CETA because they felt that CETA had not accomplished the intended decategorization.

Several staff members noted that income criteria for Title I service were particularly discriminatory to recently divorced or widowed women. While the husbands had sometimes earned incomes above the poverty line, the women had lost access to the income in the last 12 months. Unemployed women in a state of separation prior to divorce were even more disadvantaged, continued these two respondents, since often they had no income, but were still legally married and had to declare the level of the husband's income as though they were sharing it. These women were often turned away because they did not fit the on-paper income qualifications.

D. ISSUES RAISED BY EMPLOYERS

1. Relationship with CETA program. The six employers interviewed represented three PSE and three OJT locations in Mesa County. Eight of the 28 clients involved with these six employers were women and the

length of time involved with the CETA program ranged from 100 day OJTs to six month long PSEs. The salary to participants ranged from $2.50/hour for OJTs to $747/month for professional PSE positions.

2. Involvement with program. All but one of the employers had become involved with CETA as a result of the local program's initiatives. The one employer who had approached CETA had become involved because "the mayor's daughter was involved somehow" and he decided that gave some legitimacy to involving himself and his organization in CETA.

3. Definition of positions. In terms of figuring out which positions would exist with which kinds of responsibilities, none felt directed by CETA staff. Two felt that staff had interspersed their ideas and program needs into the deliberations but four felt that they as employers had most of the decision making powers in planning the types of PSEs and OJTs in their organizations.

4. Selection of clients. The selection process for determining which clients would participate in the positions varied. Three employers felt they had the major say in figuring out who would work at their work sites, two of whom indicated that they selected their employees and then sent those eligible for CETA to the CETA program for certification. Two felt that there was some kind of joint decision making process was involved with staff doing some screening and employers choosing from that group. One acknowledged that he did not know how people were chosen.

5. Needs of clients, especially women. Questions asking for their observations of CETA clients's needs were answered by five in terms of skill training needs for the skills needed in their own

organization's jobs. Three observed that many applicants had serious employment history problems with references indicating problems in interpersonal abilities in a job setting.

Child care problems were noted by three employers as reasons for tardiness or absence by head of household women. Other needs mentioned by employers were medical needs, lack of transportation, and a need to be responsible to work commitments.

Three employers did not attend to needs of women clients and did not know if CETA staff did, while two others felt definitely that CETA staff were not responding to these needs in the clients at their locations. One employer indicated that he tried to direct company services into serving some or all of these needs.

6. Affirmative Action plan. Three of the six had no affirmative action plan or apparently much information regarding affirmative action. One employer said he wanted "more coloreds and Spanish" but "don't send me more hippies or long-hairs."

When asked how more women could become involved in their organizations, three felt that it was employer's job to locate more women; "we have to," said one affirmative action officer. One thought the solution would be for more "qualified women" to apply and another felt that CETA should recruit more women.

10. Success of CETA clients. These employers' success rate with clients had been mixed. Of the 28 clients involved , 13 left the OJT or PSE before completing it, three of whom had been fired. Of the present OJT and PSE clients at all locations, each employer expressed a present plan to hire each individual.

11. Effectiveness of CETA program. When asked to rate the effectiveness of the local CETA program and staff, all six felt that the staff were generally doing what was needed. "They've done a heck of a good job," in the words of one employer. All but one of the employers indicated that they would anticipate having more involement with the CETA program in the future. The one dissenter was unsure about continued involvement because the CETA OJTs made better salaries than the other workers in his company, causing resentment among the regular employees. Although he had only women OJTs, he observed that he did not know "how a man could survive on those wages."

12. Expanding business involvement with CETA. Employers had many ideas about how CETA could improve its program. Five suggested that CETA staff should do more outreach with employers to seek their involvement, rather than wait for employers to come to them with job orders. One explained his company's policy of not listing his openings with the ES since "it would bring in too many applicants," but he was willing to take on an OJT, since this would involve a manageable number of people to be screened. One PSE employer suggested that employers "aren't reform schools," and should not be expected to handle all problems of the employees.

Various specific programs and services to clients were offered for staff consideration. Clients need "motivation and responsibility training," suggested one, with more information on their own aptitude, before enrolling them in training or OJTs.

CETA, in the mind of one employer, was better than anything being done by Social Services, since "welfare doesn't encourage people to

get off." Two respondents were skeptical about the kind of classroom learning taking place at Mesa College and other area schools where people were "learning too much about books and not enough about work."

E. ISSUES RAISED BY CLIENTS

Clients in Grand Junction seemed generally content with services offered by CETA, but were vague about the program and their relationship to it.

1. How clients learned about CETA. The 16 clients interviewed in the sample were recruited into CETA through several methods: six came on the recommendation of friends, four were referred by ES, three answered either VNB or PSE job ads in the newspaper, two were recruited through SER, and one was a WIN referral. All came seeking a job.

2. Application. All but two remembered having filled out an application, but several indicated that a staff person had completed the papers for them, and they had merely signed them. Several had no understanding that they were CETA clients and did not associate questions about income with the types of services made available to them. Two respondents felt the forms could only be completed easily by an educated person.

3. Introduction to CETA. In terms of introduction to CETA, eight felt they had some information but that it was mainly information on one particular component or even on one particular job, such as in the case of a PSE. Four felt they had received an introduction or overview of CETA, what services were available, and what choices existed for them. Three seemed confused about how their names were even chosen for the CETA study interview, because they had only a

vague sense of being a part of any program relating to their job or training.

4. Counseling. Six of the group, all PSEs, felt they had received no counseling, and said their brief contact with staff had only been to acquire the minimum necessary information to apply for the job. Others had supportive remarks to make about the staff but indicated that it was "interactional around forms," and not career planning or employability development types of counseling. The most positive clients were those counseled by a member of their same sex or ethnic group and one person who said that "I got what I needed--but I'm assertive."

5. Aptitude tests. No one in the group had experienced what they would call career exploration but rather, at best, briefly discussed what jobs they could do now and how soon they would be ready to take them. No one in the sample had taken or been offered any type of vocational aptitude test.

6. Decision for training. Although all but one of the clients felt that they had made their own choice about training or job placement, most indicated that they made the choice based usually on limited information about available options. One woman volunteered that among the first questions asked of her was her typing ability, after which the discussion centered on typing jobs.

The one person who did not choose his own training told the counselor "anything is OK," and was assigned to an OJT.

7. Explanation of job or training. Eleven of the client group felt they did not have complete information about the training or job before beginning it. Several had never seen a job description

or contract of any kind for their OJT or PSE. One PSE learned, to her shock, that the PSE job was only for six months, when she thought it was a permanent position.

8. Clients feelings about CETA program. Every client interviewed felt that their training, OJT, or PSE had been a valuable experience, although four felt their salaries were too low. In addition, all but two of the clients had been kept on by their PSE or OJT employers and the other two had found work related to their OJT or PSE experience. All seemed positive about the CETA program and staff.

Clients had various suggestions concerning the improvement of services to participants. Several PSE and WE clients felt their co-workers had treated them as second class citizens, as being somehow less qualified than others who worked there. Two PSE clients suggested that PSEs often feel isolated from the rest of CETA and have no one to talk to regarding their grievances in the work setting.

F. NEEDS OF WOMEN IN THE AREA

The clients interviewed were made up of two groups generally: those who had lived in Grand Junction for years and had low career expectations and those who had recently moved to the area and were in the process of lowering career expectations to fit the job market.

1. Job history. The best paying jobs of this sample ranged from Library Aide at $399/month to Institutional Counselor at $14,000/year, and for nine of the group, their best paying job was also their favorite. For the other seven, all but one were employed in their favorite job at present and despite a poor salary, felt that they were acquiring mobility skills and experiences for that job choice.

2. Present job problems. When asked about any problems in

the present job, the most frequent reply was inadequate salary. Of the three who felt that their salary was fair, two justified it in terms of being trainees, fully expecting large raises soon after the end of their training period. The third person, a WIN participant, felt that her low salary was adequate because she was benefiting from the receipt of part of her original welfare grant and was still receiving food stamps and other supportive services. Without WIN assistance, she felt that she would be having extreme difficulty being financially independent on her earnings alone.

Six of the group said they had problems working on weekends or doing shift work. Two head of household women noted that while working overtime was a frequent expectation of their supervisors, day care centers were not equipped to handle over-time care and working over-time created a crisis each time it occurred.

Three women said that child care was a regular concern and two others had transportation problems, since there is no bus system in Grand Junction. Other problems were in medical and legal areas.

3. Ideal job. When asked to visualize themselves in the job they would most like to do, three responded that they had no idea of what they would like to do. "I'm still waiting," said one.

For the ideal job, suggesting what salary level would be appropriate was variously answered depending largely on what one's previous salary history had been. Two simply stated that they wanted to earn "enough to live on," with no specific figure. Two with low incomes said that anything above their present salary level would be acceptable.

In terms of working conditions and intrinsic aspects of work, most had very specific desires for the job. Several wanted to work inside part of the time, with field or travel the rest of the time. Three wanted to work with youth and four wanted to be their own bosses. Some wanted mobility in their job and some were looking mainly for security. Two specifically wanted flexible hours, and two others, both heads of households, wanted a regular work day which allowed them the right to be absent when necessary for needs of their children. All but three were doing jobs that were close to what they regarded as their ideal kind of work although every respondent had various changes to suggest to the present job, except for one respondent who declared, "I'm not much of a long range planner."

4. How to get ideal job. In order for this group to achieve their ideal job, various barriers were identified as needing solution. Four PSE and OJT participants felt that the best route for them to realize their goals was to be picked up by their present employers. Two head of household women expressed the need for a better child care arrangement before they could make additional plans for themselves or even carry out the present job commitments they had now.

One displaced homemaker regretted that she had not finished college in her youth, and said she would have, if she had known about her husband's unexpected death. She felt that women needed to be counseled that "the world has changed," and that women need to have career plans and educational preparations, even if they planned to be full-time homemakers.

Other needs included more training and education, money to help

launch a small business, and a need to have a bilingual staff at human service agencies to serve Spanish speaking people.

5. Employment needs of other women. Concerning the employment needs of women in their area, six observed that locating a "job" for women was not particularly difficult as long as low pay and lack of career potential were not problems in the mind of the women. "Someone almost has to die before the good jobs are available," observed one. Five felt this situation was caused by the women's lack of skills and employment experience, with two others adding that some women are not ready to make commitments to jobs and accept deadend jobs because they do not require commitment.

Child care is a major supportive service need for working parents in the mind of five. One respondent said that CETA and other programs should be more aware that many women lack the confidence to express their needs and make career decisions. Most women need extensive career counseling before beginning their training, she continued.

One woman felt that a better salary for traditional women's jobs would ease the financial strain for many women, and take the pressure off having to enter traditionally male jobs to make enough to live on.

Women are generally "under-utilized in whatever jobs they enter," stated one woman, and they need mobility opportunities. As one male respondent summed the situation: "Women have the same needs as men--good jobs."

G. SUPPORTIVE SERVICES IN THE AREA

Although only two staff members had and used directories of local supportive services, most staff members could identify some available local resources for clients. The following information was provided:

1. Child care. Half of the group indicated that they did not know what was available in the area and/or that did not involve themselves in referrals of this sort. Three staff referred WIN clients to Social Services for consultation with their social workers and a fourth sent all day care referred clients to Social Services, asking,"Doesn't Title XX (of the Social Security Act) cover it for everyone?" Two staff refereed child care requests to the VNB in-house listings of small group day care homes and large group day care centers licensed by the Department of Social Services for day care in the area. One senior staff explained that CETA funds were not used on a short or long term basis to provide child care.

2. Transportation. One staff member indicated that he did not know what was being done to assist clients. Another explained that 10¢ a mile is available in reimbursement form to clients for a 30 day period of job search but not for periods of training or other involvement in the program. This same person did not know how many clients were receiving transportation funding. The other six staff did not use CETA funds for transportation and handled the problem by placing people in jobs or training, if possible, near their homes or suggesting that clients find or create car pools. One staff sent WIN clients back to Social Services for transportation assistance from WIN funds. Another was aware of a Community Social Services crisis transportation service but felt that it was not appropriate referral for day-to-day transportation needs of clients. Several staff noted that there is no public transportation system in the Grand Junction area.

3. Medical/Dental. One staff said he did not do this type of referral

because, "most clients have their own doctors, don't they?" Another thought that CETA funds could be used for this purpose but had never requested their use in working with clients. The other six mentioned Vocational Rehabilitation, medical services available through WIN for WIN clients, Mesa County Health, VA hospital, Family Planning Center, and Public Health. Two staff gave multiple referral locations, the other four gave single names of local agencies.

4. Mental Health/Counseling. Everyone responding had at least one referral agency for clients with such needs. The local Mental Health Center was mentioned by six. Two staff referred clients to VNB. Also mentioned at least once were Center for Marriage and the Family, Community Social Services, Salvation Army, school social workers for youth, and Vocational Rehabilitation.

5. Legal. One staff had no information, but six mentioned Rural Legal Services as a referral. But one said, "I don't know what they do with 'em out there." Another said Legal Aid had a referral list of private lawyers who will accept sliding scale fee clients.

After interviewing staff, a copy was obtained of the Directory of Human Services Agencies of Mesa County, published by Mesa College. The Colorado Women's Resource Book, by Marilyn Auer and Constance Shaw was also consulted. The following is a partial listing of supportive service agencies in the Grand Junction area, compiled from these two sources:

Child Care
- Virginia Neal Blue Women's Resource Center (listings and information)
- Dept. of Social Services (listing, information, and funds)
- National Organization for Women (has local "child care networks")
- Child and Migrant Services (provides care during harvests)
- Community Social Services (provides day care referrals)
- Grand Junction Community Nursery School (facility)
- Head Start (facility)
- Hilltop House Rehabilitation Center (facility for handicapped)
- Mesa College Child Development Center (lab school facility)
- Mesa County Assoc. of Child Care Parents (referrals to members)
- Mesa County Community Coordinated Child Care Assoc. (referrals)

Transportation
- Community Social Services of Colorado West - limited services

Medical/Dental
- Planned Parenthood - several offices in Northwest Colorado
- Dept. of Social Services - family planning assistance available
- Child and Migrant Services - some health services for migrants
- International Childbirth Education Association - information
- Local hospitals: Grand Junction Osteopathic, Lower Valley, Mesa Memorial, St. Mary's, and Veterans's Hospitals

Mental Health/Personal Counseling
- Programs for alcohol and drug abuse: AA, Al Anon, Al Ateen, Bridge House, Clearview, Project Awareness
- Virginia Neal Blue Women's Resource Center - counseling and courses in personal growth, marriage and the family, assertiveness training, transactional analysis, etc. Rape Crisis Center and Battered Women services
- Mesa County Mental Health Center - in- and out-patient services
- Dept. of Social Services - individual and family counseling
- Parents Anonymous - group counseling for abusive parents
- Attention to Youty, Division of Youth Services and Juvenile Parole - services for youth
- Center for Marriage and the Family - provides counseling
- Salvation Army - provides counseling
- Colorado West Community Action Program - financial and alcoholism
- Crisis and Suicide Prevention Center - provides counseling
- Goodwill Rehabilitation - sheltered workshop, work counseling, etc.
- Mesa College Career Center - vocational counseling
- Mesa County Valley School District Special Services Dept. - counseling
- VA Veterans' Benefits Counselor - provides counseling to veterans
- Assorted services to probationers and senior citizens

Legal Services (all provide legal services)
- American Civil Liberties Union
- Colorado Attorney General's Office
- Colorado Civil Rights Commission
- Colorado Rural Legal Services, Inc.
- Colorado State Public Defender

General Referral and Information
- Colorado West Community Action Program
- Dept. of Social Services
- Virginia Neal Blue Women's Resource Center
- Child and Migrant Services, Inc.
- Community Social Services of Colorado West
- Council on Human Resources

One staff member explained why he felt that few staff did supportive service assessment and referral: "Counselors don't know about services in the area and there's no emphasis on learning it." Another indicated that "counselors are trained to place first and only offer other components and services when they decide what's best for you." A third said that these issues don't come up much" in working with clients, with a fourth viewing client's expression of supportive service needs as "excuses for not working."

H. SUMMARY

Grand Junction is a town with limited resources and it is understandable to a degree that it has a CETA program which is less sophisticated than other areas. But it has some definite problems. The CETA clients in Grand Junction are handled as ES clients in a bureaucratic manner, and CETA staff are expected to be ES employees. The program as a whole is mediocre, even though it is performing according to BOS expectations.

In addition, the staff is poorly trained and there is some friction among certain of the staff members. The staff also receives directions from too many sources-- from the ES office manager and from state ES and BOS levels. The staff has little share in the decision making processes and little understanding of many of the problems of CETA clients. Unfortunately, the whole BOS structure has immense problems to solve before the system is a workable one, and perhaps the system is too large and spread out to ever work.

1. Information taken from grant narrative and statement of work portions of BOS Title I,II,III, and VI documents for FY 76 and 77. Because of the non-existence of a published comprehensive CETA plan, these documents were made available by BOS for in-office use only. They were xeroxed by CCSW staff, because BOS "didn't have time" to provide the requested documents themselves.

COLORADO SPRINGS

A. OVERVIEW OF SITE

Colorado Springs began its CETA program in 1974, one of the first prime sponsors to be funded in Colorado. Since then, it has changed and evolved, and continues to change, priding itself on its innovative and progressive program.

Colorado Springs and El Paso County have the only CETA consortium in Region VIII with a total budget in fiscal 1976 of over $3.5 million and an enrollment of over 3500. Projected budgets for 1977 are $1,376,750 for Title I, $239,675 for Title II, and $890,750 for Title VI. Funds for Title III youth programs have not yet been allocated.[1]

The population of El Paso County is 304,500 and Colorado Springs alone has a population of 185,700. Of this population, 24,409 or 11.3% is considered to be poor.

Based on unemployment and poverty criteria the following breakdown of target groups has been selected for fiscal 1977:

Black-17%
Spanish-American-21.5%
Anglo-57%
Other-4.5%

Female heads of households have been selected as a special target group since they have a higher unemployment rate than their male counterparts and earn less when they do work. Forty per cent of female heads of households are poor. For these reasons, in fiscal 1977, the aim in Colorado Springs is to serve 63% female and 37% male clients.

The Colorado Springs CETA program uses a delivery system called a "staffing grant" method by the CETA Administration. Staffing grants with enough money for administration are awarded to local

agencies. In 1977, the funded agencies are Urban League, SER, Virginia Neal Blue Women's Resource Center, Veteran's Outreach Program, Youth Employment Program, and ES. Other funded agencies--Employee-Ex and the Department of Social Services--are partially or wholly staffed by PSEs.

A typical client coming into the program would go to one of these agencies to fill out an application and go through intake, assessment, and counseling.

Most clients requiring ABE or GED education classes are referred to SER. A Learning Center operated by SER is set up to bring clients from fifth to eighth grade functional level in 16 weeks. SER also operates GED and clerical upgrade classes. Other vocational training is referred to El Paso Community College.

A new system for assessment of clients has begun in Colorado Springs and will be expanding. Clients, selected by a committee of agency staff, administrative staff, and Advisory Board members, are sent to Goodwill Industries's vocational evaluation service. This in-depth, three day testing schedule is used to plan employability development plans with clients and route them into appropriate segments of the program. The administration plans to use the Goodwill evaluation system extensively in the future.

Job development for all the funded agencies is now handled through the administrative office, although each agency is still expected to do some direct job placements. This new system, begun in FY 77, hopes to promote efficiency and avoid duplication of effort between agencies.

The PSE program in Colorado Springs has created some interesting jobs. Fountain received its first full-time, paid fire department with PSE funds and Palmer Lake now has a full time police force for the first time, thanks to PSE funds. The NAACP, Women's Health Center, and the Boy's Club are all staffed, partially or totally, by PSEs.

There are more than 70 PSE locations in Colorado Springs at the present time. These PSEs are used to staff positions and thus increase linkages between the CETA program and other community resources in town, such as the day care centers, mental health centers, and family counseling centers.

Other ideas for projected plans include increased use of group OJT contracts with large employers, and an industrial day care center located near or at the work site, and possibly staffed by PSEs or OJTs.

B. SELECTION OF SAMPLE

A random sample technique was used to select interviewees in Colorado Springs, as it was in other sites. Attempts were made to reach nine OJT clients, of which six were finally interviewed; four clients in classroom training were interviewed out of an attempted five; and four PSEs were interviewed out of five called. A total of 14 clients were finally interviewed.

Nine employers were contacted and interviewed using the same random sample technique. There are a total of 44 CETA professional and support staff in Colorado Springs, including both administrative staff and sub-contractors. From these, 13 were interviewed, including an Advisory Board member. Attempts were made to interview at least one professional staff person from each of the sub-contractors, as well as staff from the CETA administration.

C. ISSUES RAISED BY STAFF

The staff in Colorado Springs seemed to be well informed about their program and how it worked. Most problems seemed to be centered in expectations and implementation of the delivery system used in Colorado Springs. The strong, centralized administration is quite powerful, and the sub-contractors sometimes felt left out of the decision making process. Some staff members even felt that impossible demands were made of them.

But the general tone of the program is one of creativity and progressiveness. The staff members interviewed generally seemed excited about the unique design of the program and its potential.

1. Model for clients in program. Most of the staff members interviewed had a good grasp of their own job in the CETA system (12), and eight seemed to know generally how the system as a whole worked. When asked to describe a model for a client's entry and experience in the program, most of the staff answered in detail describing the progress of a client in a step by step manner.

2. Planning process in area. When asked to explain the planning process in Colorado Springs, answers varied. Seven staff members said the administrative staff made all decisions, six believed that decision making was a shared process between the administration and the Manpower Planning Council (MPC), and two did not know who made the decisions.

One staff person said, "Everyone has input," but another disagreed, stating, "the council doesn't counsel," and another added, "the MPC abdicates to the Administration." There was also

disagreement as to the amount of input the sub-contractors give to the planning process, one staff person observing that the administration had a hard time getting the sub-contractors to submit ideas and one sub-contractor complaining they try to give input but are not listened to: "Providers give ideas, but they aren't followed by the administration."

3. Identification of general needs of clients. It was generally agreed by the staff interviewed that population and unemployment statistics are used to determine the population to be served (9 staff.) Of these, eight knew that the administration had its own formula based on statistics to determine target groups. Two did not know how populations to be served were determined.

4. Needs of women. When asked about the needs of women clients, most staff interviewed had several ideas to offer. Ten said women need more training, seven noted that women had child care problems, and six observed that women have transportation problems. Five staff mentioned the problems of displaced homemakers, "women in transition," as one staff person called it. These and other women need job search training, according to three staff members, to teach them how to look for a job, how to fill out an application, and how to behave in an interview.

Five staff persons said more emphasis should be given to non-traditional jobs, because, as one person said, "that's where the $3 an hour or more is." One staff person emphasized that non-traditional jobs or other better paying jobs are necessary to get women off welfare, because so many benefits are provided to welfare recipients, such as child care, food stamps, and medical services.

"What is she going to do if she leaves welfare to wash dishes for $2 an hour," the interviewee asked.

Four staff people said that women need more career and personal counseling, feeling that many women have "a self-defeating attitude," and a "self-image problem."

5. Ability of program to meet women's needs. When asked if the program was meeting these needs of women, the response was varied. Nine people thought the program was doing a good job of meeting needs. "I am very proud of it," one person said. One staff member thought the program was not meeting women's needs.

6. Internal program evaluation. According to the staff interviewed, all sub-contractors are evaluated twice a year by the CETA administration. Daily, weekly, or monthly internal evaluations are also used to determine if the program is meeting placement goals. "All sub-contractors have performance standards" imposed on them by the administration, said one.

7. Relationship between program and DOL. When asked about the relationship between the CETA program and DOL, the response of the staff differed. Seven said they did not know or had no personal contact with regional or national DOL. Five believed the relationship was helpful, and one person said they had only "paper contact."

One person felt the relationship was not helpful, stating that it was a "one way system." They added, "Instead of us telling DOL what we would like to do, they tell us what we will do."

One person disagreed with the veteran's preference rule imposed on CETA programs by DOL, observing that in Colorado Springs, "veterans aren't the neediest group."

8. DOL evaluation. Next, the staff was asked how useful the evaluations done by DOL were to assess program effectiveness. Six people knew little about the evaluation, one explaining that "it doesn't get down to us." Three thought the evaluation was helpful and three felt it was not helpful.

One staff person said the categories used by DOL are too limited, because they "discounted a lot of strengths." For example, bringing a person from fifth to eighth grade functional level in a class does not get any credit, the staff person explained.

Another person thought too much time was spent in arguing with DOL about regulations and definitions, believing that "all that shit isn't as important as people services."

9. Strong points of program. All staff members had comments to make when they were asked to list the strong points of the program. The answer given most frequently noted the diversity and flexibility of the Colorado Springs CETA system, and the willingness of the administration to experiment and try new things, mentioned by four staff members. These people talked about the "good basic structure" and "good design" of the program.

Other points were more varied. One person talked about the "identification with the community," especially with minorities, that the sub-contractors have, adding that minorities have a tendency to avoid ES but will come to a community based organization where they feel comfortable. One person praised the PSE system, calling it a "boost to community based organizations."

Another staff person felt the new assessment procedure being

developed with Goodwill was a strong point of the program. For example, she said, one young woman, with previous juvenile court problems, had come into the program through Employee-Ex, and had completed Goodwill's testing program. They discovered she had an IQ of 148 and promptly obtained a Basic Educational Opportunity Grant (BEOG) to send her to college. Without the tests, the staff person concluded, she would probably have ended up doing factory work.

Also mentioned as strong points by at least one person were:

--a good relationship with industry
--good placement rates
--strong supportive services budget
--remedial education, bringing clients from 5th to 8th grade level

10. Weak points in program. But staff also had ideas about parts of the program that needed improvement. Six people believed the program would be improved with more and better cooperation and coordination between agencies. Five thought the program needed more staff, one mentioning that "we are so inundated with clients that it's hard to do a thorough assessment."

Two people thought the quality of the staff was mixed, because "many staff are new or unevenly skilled. One person disliked having to "play the numbers games of statistics," and another complained about the "day to day paper shuffling."

Another person felt that followup should be improved, feeling it was too haphazard and sporadic. Other problems mentioned included a need to be more visible, a need to improve outreach, and unrealistic placement goals.

11. Comments on CETA law. Concerning the CETA law itself, the staff agreed (10), that it was a workable, generally good plan, but some wanted to see changes. Five staff members were concerned over local interpretation of the law, fearing that local control could lead to poor service. Five also complained about the veteran's preference rule, thinking it unfair to needier groups.

One person complained that the priority of un- and under-employed people is not being implemented, with "more money going to unemployed college graduates" than the real disadvantaged.

D. ISSUES RAISED BY EMPLOYERS

Employers in Colorado Springs seemed better informed in general about the CETA program than employers interviewed at other sites. Some even had copies of the CETA Comprehensive Plan.

1. Relationship with CETA program. The nine employers had CETA clients working for them in both PSE and OJT positions. Of a total 92 CETA clients working at the job sites, 57 were women.

2. Involvement with program. All but one of the employers became involved with the CETA program through their own initiative. As one employer put it, "I had another friend in business who had good success with CETA and he recommended the program." In one case, the employer hired a trainee, then heard about the CETA program and sent his new employee over to CETA to be certified and sent back as an OJT.

3. Contractual agreements with CETA. Most employers had individual contracts with CETA, but two large companies had group contracts. One PSE employer complained about the necessity of renewing

PSE contracts every six months, saying that he had to play "musical papers" with CETA twice a year to keep his PSE employees.

4. Definition of positions. Eight of the employers said they made the decision about the amount and type of training an OJT client received and defined the tasks to be performed by a PSE employee. Three said the decision was made jointly with the CETA administration.

5. Selection of clients. In most cases, the employers hired their CETA employees from a group sent over by CETA (in 5 cases.) Two said the decision to hire was made jointly by the employer and CETA.

6. Needs of clients, especially women. Employers listed several items when asked about the needs of CETA clients, especially women. As one employer said, "We see the sad side of women."

Job related needs were listed most often by employers. Five thought that CETA clients need more skill training or more education, such as GED or ESL training. They also noted that CETA client women often have a sketchy or non-existent employment history, making it difficult for them to get work. But one mentioned that often employers "require degrees for jobs that don't really need them."

Five employers realized that women employees often had child care problems and four mentioned transportation problems. One noted that women often have "no car or a broken car."

7. Are clients needs being met. Three employers were not sure if anyone was helping to solve women's problems. Two thought they were trying to meet the needs of women employees, one mentioning that he hoped to start an industrial child care center soon with the help of CETA. Two employers thought CETA was probably taking care of the needs of clients, and one did not know.

But one employer did not feel it was his job to worry about the problems of CETA clients: "We aren't psychologists here, just employers."

8. More women involvement. When asked how more women could become involved in their program, three employers answered that it was up to CETA to recruit more women and one said he would take more women if they would just apply.

But two employers were not interested in hiring women. One employer with a printing company felt women did a good job in some areas but did not like to see them working at the presses because it was "a dirty job," and he "hates to see women doing it."

9. Affirmative Action plan. Five of the larger employers had affirmative action programs, and felt that the CETA program was a good way to help fulfill its requirements.

10. Success of CETA program. Most of the employers interviewed (8), thought that CETA was doing an effective job and were planning to continue or expand their relationship with the CETA program, one adding that the program was "great."

11. Expanding business involvement with CETA. Most employers had ideas to suggest to improve the program. Several employers suggested that CETA do more advertising with the business community to explain what CETA is and how it can help business. One employer added that CETA should advertise how successful CETA clients have been in work settings, to "let businessmen know they aren't hiring riff-raff."

One employer said he felt that CETA should "do more outreach to minorities and women," another adding that business needs to break its own stereotypes about women and minorities.

E. ISSUES RAISED BY CLIENTS

The clients interviewed gave answers typical of clients at other sites. Most felt their CETA experience was worthwhile and were willing to talk to the research staff about it. The research staff interviewed past and present clients in all components of the CETA program.

1. How clients learned about CETA. The clients interviewed had widely varied ideas about the program. Of the 14 clients interviewed, nine had heard about the CETA program through some type of advertisement, such as newspaper or radio ads. Four had heard about the program through friends and two had been referred to CETA from another agency.

2. Why clients went to CETA. A majority of the clients (9), wanted a job when they went to CETA, and four hoped they would receive training from the program. One was required to go by WIN.

3. What happened to clients at CETA. Most clients filled out applications and talked to someone before entering any part of the CETA system, but one person who had been placed in an OJT setting did not even know that she had gotten her job through CETA.

4. Application. Nine of the clients interviewed felt the application they filled out was reasonable and asked necessary questions, but two thought it unreasonable and four did not remember enough about the application to answer any questions. Several clients made suggestions to improve the application. One suggested that more space be allowed for comments and one client did not understand the question about the income criteria.

5. Introduction to CETA. Most of the clients (10), said they did not receive a complete explanation of the various programs and services available from CETA. They felt they only received an explanation of the part of the program they entered. Three felt they received a complete explanation and one woman did not remember.

6. Counseling. The quality and amount of counseling received was mixed, according to the clients interviewed, with four believing it to be unhelpful and three considering it helpful. Six said they received no counseling at all and three felt they needed more counseling.

7. Decision for training. Eight women felt they were responsible for the decision of enrollment in whatever part of the program they were in, but six said that the decision for enrollment was based on available opportunities at the time.

8. Explanation of job or training. When asked whether their training/job situation was explained to them before they began, eight responded that the explanation was complete, while five said the explanation was incomplete in some way. One woman mistakenly believed that she was guaranteed a job after her classroom training.

One Japanese woman was enrolled in typing classes. Eventually everyone realized she could not easily become a secretary because she could not read or write English. Now, the woman is back working as a waitress and hopes to go back to school, this time to learn computer programming.

9. Clients feelings about CETA program. Nine women interviewed completed their job or training in the program, two quit because they got another job, and one was dropped by the program. Most thought

their experience with CETA was a good one (10). Two clients felt, though, that they "ended up right where they started."

One woman said that CETA "saved my life." She was divorced, with a child and on welfare when she went to CETA. Since she had clerical experience and was interested in law, CETA developed an OJT for her as a legal secretary. She has now become a divisional clerk for a county court judge with plans to become a paralegal.

10. Job Success after CETA. Seven of the women who had completed their CETA involvement found employment; three were still looking. The jobs ranged from traditional jobs as secretary, waitress, and receptionist, to more unusual jobs as outreach worker for a community center and a divisional court clerk. The payroll was from $400 a month to $765 a month, but most of the salaries were less than $500 a month. Only three were above $500.

F. NEEDS OF WOMEN IN THE AREA

In this section, the research staff tried to find out what job possibilities the women had thought of and whether CETA helped them to reach their goals.

1. Job history. When asked what their present or last job was, most women interviewed responded with traditional jobs. The best paying jobs the women had ever held were slightly different, including a telephone representative, a caseworker for the Department of Social Services, and a teacher. The list of favorite jobs was different still. It included many of the best paying jobs held, but also had some others, including one woman whose favorite job (but not best paying) was doing handy work in a body shop for cars. The best paying job for all the women interviewed paid $765 a month.

Only one other woman had a job that paid more than $700 (710).

2. Present job problems. Most of the women had some problems on their present or last job. Nine of the 14 clients considered their salary inadequate, and nine also had children and therefore had to find some type of child care when they were working. Seven did not like the work they were doing, considering it unsatisfactory or demeaning.

Other problems mentioned were few or no health or other benefits (6), long or inconvenient hours (4), poor work conditions (2), transportation problems (2), and medical or legal problems (2).

3. Ideal job. When they talked about the type of job they would like to do if they could, most women chose something different from their present job. These ideal jobs ranged from work with disturbed children, to law, to commercial art, to public relations. Only one woman, a bookkeeper, wanted to continue working at her present job.

The women were asked what salary they needed to live on when they had their ideal job. Most had an unrealistic idea of the amount of money they needed to live adequately. One woman said she would accept $2.50 an hour as a beginning salary. Half of the women had no idea how much money they needed for expenses, or what salary they could expect to make at their ideal job. Only one woman said she wanted and needed to make above $1000 a month.

4. How to get ideal job. To get their ideal job, most of the women, (11), felt they needed either vocational or academic training. One woman needed ESL training. Four said they wanted to go to school

but needed money to pay for the training to achieve their ideal job situation. Two women said they needed more experience, and two asked for more counseling. Two said they would have to make additional child care arrangements.

5. Employment needs of other women. When asked generally about the employment needs or problems that other women have, the clients had a lot of suggestions. Transportation was listed as a problem by six of the women, and six also listed child as a need women have. Six said that what women need are good jobs, two adding that women need to become more aware of the opportunities available. To take advantage of these opportunities, three women said women need to become more assertive and independent. One woman said older women have a problem because they are not considered for some jobs, and one woman said the position of the homemaker needs to be upgraded. One woman said women living in outlying parts of the county have all sorts of problems, since they are forced to come into Colorado Springs for most needs.

G. SUPPORTIVE SERVICES

The staff in Colorado Springs seemed to have a good grasp of supportive services available locally and most were able to give an extensive list of agency referrals they said are used regularly. One staff said, "We have picked up all kinds of things if we were sure it was needed for the client to make it."

Five areas were specified in interviews, and everyone interviewed had some knowledge about each area. As one staff person said, "There is no limit on support services," adding that clients with

needs were passed on to the CETA administration, who decided how much they could provide for each client. One staff felt the large supportive services budget and the emphasis placed on support by by administration was one of the strong points of the program.

1. Child care. The staff did a lot of referring when clients had child care needs, with eight referring clients to local child care centers with sliding scales. Six also mentioned that they referred women to social services for child care listings and for child care subsidies when they qualified. Seven staff noted that in emergency cases, CETA would pay for child care. Not one of the staff interviewed answered that nothing was available or did not know what was available.

2. Transportation. When asked about transportation, 12 of the 13, staff answered that CETA pays for bus tickets and gas coupons for clients who need them. Three staff added that they try to solve additional transportation problems by finding clients jobs near their home or on a bus line and two staff also tried to encourage carpools.

3. Medical/dental. Eleven staff members said that CETA uses funds to pay for medical services when necessary. Several had anecdotes to tell about clients who received special medical or dental care with CETA funds. Seven members of the staff also said they referred clients to local health clinics when possible, for free or low cost medical care.

4. Mental health/personal counseling. All 12 of the staff answering this question said they referred clients to other agencies such as the Pikes Peak Mental Health Clinic or the Family Health Service.

5. Legal. Clients who needed legal services were referred to free or sliding scale services locally by 12 of the staff.

After interviewing staff, a copy was obtained of the Directory of Community Services of the Pikes Peak Region. Six of the staff, who dealt directly with clients, said they had copies of the directory and used it.

The 180-page directory listed five referral agencies for child care, several for legal assistance, and over 10 agencies for mental health or personal counseling. There were at least a dozen agency listings providing medical care.

H. SUMMARY

Colorado Springs was in some ways the most creative, progressive of the sites visited. It is an example of a multiple contractor CETA system with high emphasis to women as target groups as well as contracting to a Women's Resource Center. It has potential to be even more innovative, with creative uses of PSEs, OJTs, and an exciting assessment system being developed.

But it also has some problems. The biggest problem seems to be the conflict between the CETA administration and the sub-contractors. All power is centralized in the administration and the CETA director. The sub-contractors are unhappy with the present system. They feel the administration sets arbitrary standards and goals and they want

to have more input into the decision making process. There is a lack of coordination and cooperation among sub-contrators which also needs to be solved by the sub-contractors and the administration together.

If these problems are corrected, Colorado Springs will be moving in the direction of becoming the innovative, progressive program it has the potential to be.

NOTES

1. Information taken from Comprehensive Employment and Training Plan for Colorado Springs, El Paso County; and from information obtained from Bob Harden, Fiscal unit, ETA of DOL, Region 8.

BOULDER COUNTY

A. OVERVIEW

Boulder County is one of five major counties in the Denver-Boulder Standard Metropolitan Statiscal area. The current population of the county is estimated at over 165,000.[1] Most of the county's population is within an hour's commuting distance to Denver and many people work outside Boulder. A major force in the employment pattern of Boulder County is the University of Colorado, located in Boulder and influencing employment there significantly.

The 1977 Comprehensive Manpower Plan for Boulder County states that the CETA program there will serve economically disadvantaged, unemployed, and underemployed residents of Boulder County. The kind and level of services available will be based on need, with higher levels of service going to severely disadvantaged and long-term unemployed. The program's Title I goals for FY '77 are to serve 488 clients in one or more activiites and to secure unsubsidized job placements for 201. Of these, they plan that 286 or 64% of the program participants will be unskilled and disadvantaged.

The total Title I budget for FY '77 in Boulder is $820,014, part of which funds the new Women's project, explained later in the report.[2] Title II funds total $236,307, and Title VI has $824,617.

A point system is used in Boulder to determine priority of need when people apply to enter the program. Categories and points are:

CATEGORY	POINTS
1. length of unemployment (one point per quarter of unemployment up to 5 points)	1-5
2. family size (one point per dependent)	1-up
3. ex-felon	1
4. drug abuser (gone through program or will enroll in program)	1

5. former institutionalized psychiatric patient	1
6. minority	4
7. physical handicap (one point per 10% of handicap	1-up
8. vet status	
Vietnam	3
Vietnam era (but not Vietnam)	2
Other	1
9. high school dropout	2
10. receiving public assistance	2
11. priority of chronological order of CETA certification (one point per quarter)	1-4
12. head of household with dependent/s	2
13. primary wage earner	2
14. migrant & seasonal farm worker	4

Program components in Boulder include evaluation clinics, job readiness workshops, classroom training, OJT, PSE, and WE. Most participants do not experience all of these components.

Besides the regular CETA program in Boulder, a special project for women began in October, 1976. The funds for this program were originally applied for out of Title III significant segment funds, but were received finally under Title I. The grant was written by the Boulder County Women's Resource Center with input from the CETA staff, but was awarded to the Boulder County CETA program. The $165,000 grant will run for one year and is staffed by three full time employees and volunteers.

The objective of the project is to serve economically disadvantaged women, especially single female heads of households, women over 44, (particularly displaced homemakers), minority women, and discouraged workers.

The project will serve approximately 155 participants with a goal of placing 105 (75%) in unsubsidized employment. About 20 women will go through intensive training and counseling to lead them to entry level management careers; another 35 will be trained

and encouraged to start their own small businesses. The remaining 100 will receive job hunting skills and confidence building techniques for greater opportunity in finding employment. The project will place a greater emphasis on counseling and supportive services than many CETA programs do.

B. SELECTION OF SAMPLE

In Boulder, 15 of the 21 staff members were interviewed. A random sample technique was used to choose 46 client names, of which 18 were interviewed. Of these clients, two were OJTs, four were in classroom training, three held PSEs, three were WEs, one was a direct placement, and one was a negative termination.

A similar random technique selected 15 employers, of which the research staff interviewed ten.

C. ISSUES RAISED BY STAFF

The staff in Boulder had some interesting ideas to share with the research staff and some enthusiasm about the potential of the CETA program there. But the feelings expressed by some people were those of alienation, confusion, friction, and disagreement. These can be discerned from their answers.

1. Model for clients in program. When the staff in Boulder was asked to describe a model of the client flow through their program, the variety and amount of explanation varied. Five staff members seemed to have only a partial idea of how certain parts of the program worked, three had a good overall sense of the whole program, and the others could only describe their own section of the program.

There was disagreement between some staff members about the value of certain portions of the program. One staff person praised the Vocational

Technical secretarial course, saying it did "an exceptional job." But another observed that some clients get "pigeon-holed" into secretarial courses, just "because the class exists." This disagreement among staff members was consistent and kept coming up. There did not seem to be a consensus among staff members about the value of the CETA program.

2. Planning process in area. The staff was divided in its opinion about who does the planning in Boulder, with six believing the decision making process was shared by staff and the Advisory Council, five stating that the administrative staff alone made the decisions, and the others admitting that they did not know who did the planning.

There was some ambivalence expressed about the quality of the planning done, with one person stating that there is "no real planning or good existing data on clients." Another added that "planning is in a rut."

One staff person said, "The staff presents plans and options," for Advisory Board consideration, and another said the council is "a rubber stamp for the staff." But another felt just as definitely that "the council is not a rubber stamp to the staff," and another added, "the council is terribly involved."

Another person had an even different opinion, stating that the county commissioners actually "make the final decisions," while another said that the county commissioners "accept mostly what the Advisory Board lays out, based on staff input."

Several people mentioned past problems among county commissioners, the Advisory Board, and the staff, with one stating that the county

commissioners "trust the council now that the obstructionist council members are gone." Another staff agreed, mentioning that the county commissioners "fired the board members who made waves." One person remembered that there was "public outrage" when the county commissioners replaced the Chicano CETA director with an Anglo.

From the preceding remarks it seemed that there was some conflict and disagreement in Boulder about who actually made the decisions and who had final authority. In the past, the conflict seemed to have been even stronger.

3. Identification of general needs of clients. When asked how the general needs of clients were identified in Boulder County, one staff person said, "haphazardly." Six said statistics were used to identify needs and six more said the staff or council made the decisions of whom to serve. One person did not know.

Several people had comments to make about problems they saw in identifying needs. One person said that there are "lots of assumptions without back-up data" about client needs, and another said the staff used surveys and census data which were "invalid."

One staff person said that "several conflicting studies exist, each confirming the needs of its own favorite group." And finally, one person explained that a lot of the problems are caused because "Boulder is a weird county, made up of transients and rural folks."

The staff from the women's grant used a different approach to identify needs and choose clients. According to the staff, clients for their program were chosen based on statistical data, a point system of need priorities, and on personal observation by the staff.

Women with a management orientation were a priority group, since "Better Jobs for Women in Denver does manual and technical jobs and does it well." So the women's project decided a management focus was needed and appropriate since Boulder is a center for "white collar industry."

4. Needs of women clients. Next, the staff was asked about the needs of women. Staff members saw numerous problem areas and some seemed to have a good grasp of some of the problems women face.

"Boulder has many well-educated women who are unemployed or under-employed," said one, and another added that many women are "separated and divorced heads of households," or are "women emerging from shattered marriages, whose husbands' incomes disqualify them" from receiving help from CETA.

These women "in transition " need many things, according to the staff. Among those listed were child-care (mentioned by 8 staff), career counseling and exploration (5), personal counseling (4), a good paying job (4), transportation (4), and training (3).

"Most of the women are without clear goals," and need a lot of "ground work," "confidence raising," and "group support," said one staff member.

"They need to be educated on survival techniques," another added. And a third stated that "many aren't emotionally ready to work." Those who are working are often in "survival jobs without a future," according to one staff person.

Another group of women who have special needs are "Chicanas and especially Chicana heads of households," said one person.

"Chicanas lack social skills and a good work history," explained one, adding that "more emphasis should be on Chicanas."

5. Ability of program to meet women's needs. When asked if the CETA program was meeting women's needs, all but one of the staff agreed that needs were being met only partially. One person felt that the CETA program was doing a good job of meeting these needs.

One person explained that the Boulder program is "not completely serving female heads of households" because "supportive services are so expensive," and the "money is not there to serve many."

Several felt the new women's grant was "addressing the need" of women "more thoroughly" than the existing program. And a women's grant staff person praised the workshops offered by their program, as offering supportive counseling.

6. Internal program evaluation. The staff was asked next if they had an internal system to evaluate their own program and seven felt they had some type of evaluation system in use, although some disagreed about what the evaluation was. Several staff members said a system is being developed now, one pointing out that a Director of Planning and Evaluation had recently been hired.

7. Relationship between program and DOL. When asked about their relationship with DOL five staff said,in the words of one, that the relationship was "fairly casual and informal," but a "good, workable relationship." The rest had an unclear idea about what the relationship with DOL was.

8. DOL evaluation. When asked how they felt about the DOL evaluation, staff either replied that they did not know (8), or that

it was not helpful (4). No one thought the evaluation was helpful. "They're concerned with numbers, not quality," was a typical reply.

9. Strong Points of program. The staff had several points to make when asked about the strong points in the program. One person was enthusiastic about the program, saying it is "tuned in to what's needed in Boulder," and another added that the "place is pulling it together and getting a little more refined."

Another person considered it a strong point that "CETA in Boulder doesn't want to be strictly a poverty program."

One person praised the "counseling unit and the point system for entry," and another liked the "human approach" used in Boulder, feeling that the staff is "receptive to more than just outward needs."

Women's Grant staff felt enthusiastic about their new program, one saying she was "proud of the overall concept of the program."

Other strong points mentioned by the staff were a good comprehensive plan, the administration, good target priorities, a capable staff, and an improved MIS system.

10. Weak sections of program. Next the staff was asked what parts of their program needed improving. One person mentioned that even with monthly meetings for "thrashing things out," there seemed to be little information exchange between units. Another person added that the program has "organizational problems," adding that the staff needed "clearer goals and roles."

"Most of the staff don't know the target group numbers or the overall plan," said one. And another agreed that the staff did not seem to have a total view of the system and "they barely know their own part."

One person observed that "the counselors and the job developers blame each other for incompetence." Speaking about the counselors, one person said that "counseling is more therapy and not enough employability planning." Another said that "clients are not assessed deeply about how really motivated to work they are."

There were also complaints about job developers. One person said that job developing was done only in Boulder and should be done county-wide. Another noted that "they need more creativity in job developing. The traditional knocking on doors is not working."

One person suggested that there should be a "match service for clients--job developers would then literally create positions rather than wait for openings." But one person defended the job development unit, saying that it is the "garbage disposal," where clients are sent when nobody else knows what to do with them.

There were other problems mentioned. One person suggested that "only clients who are assertive get served," and another believed that "25% [of clients] lie about income eligibility because they've been coached."

One person observed that the "program is not well planned or thought through." Another felt the solution for Boulder was to have a "comprehensive plan for Boulder County," with all agencies who now have separate plans "coming together to plan together."

In this same vein, another staff person suggested that "there is not enough emphasis on the county where the real poor are." This staff person explained that Boulder has two types of poor: the real disadvantaged and the economically disadvantaged, made up of "young middle class kids who love the mountains."

Several staff had concerns about certain segments of the program. "Classroom training is a joke," one person said, since it is not coordinated with employers.

Another staff person wanted to see money taken from PSE positions and put into OJT slots since "it's better to get a permanent job than a temporary one."

Other concerns included the need for additional staff and more office space, better screening, and the feeling by one that the staff is "expected to serve too many clients for the money."

Staff from the women's grant were concerned that they have only three paid staff to work with 150 women and must "exploit" volunteers to meet the needs of client women. One interviewee was concerned that the staff from the Women's Resource Center wrote the grant for the women's project, but funding was allocated totally to the CETA program.

11. Comments on CETA law. Finally, the staff was asked about the CETA law itself, drawing a mixed response.

"CETA has some real genius," said one, "but the regs. are done by nervous bureaucrats." "The regs are much too complex; you don't understand half of what you read," said another.

One person complained that "the feds. want numbers and that blocks working with the truly disadvantaged who cost money to serve."

But another staff felt there is "too much emphasis on the disadvantaged, long term unemployed--the other unemployed need jobs too."

Although one person praised CETA's "flexibility," another felt the flexibility allowed that "shit hole programs will be created in shit hole towns," and needy people might be left out.

Finally, one person worried about CETA's future, stating that "Congress now gets BS figures and if they figure it out, CETA may be eliminated."

D. ISSUES RAISED BY EMPLOYERS

In general, the employers in Boulder seemed satisfied with their involvement in CETA. Some did not appear to be too aware of the goals of CETA and did not know exactly how the program worked.

1. Relationship with CETA program. Of a total of 30 clients hired by employers in PSE, OJT, and WE slots, 13 were women.

Most of the employers became involved with CETA through their own initiative (6), and two were invited by CETA to become involved.

One typical employer found out about CETA when it was "recommended from next door." Another said he found out about the program when a girl applied for a job and then arranged to have it made into an OJT position.

One employer with a WE person felt he "never got much information on Manpower goals. I really didn't know what was expected of me."

2. Definition of positions. Most employers (7), felt they defined the positions in their company. As one put it, "The agency writes its own job description."

Three employers worked jointly with CETA to define positions. One explained, "SER gives an outline of skills to be developed," but went on to say, "we can't do training in all areas despite its being in the contract."

3. Client selection by employers. Four employers said they selected their own employees, two chose employees jointly with CETA, and one said CETA chose the employee. One employer said he chose employees by looking for those "who seemed to want to work." Another said he looked for "career oriented people."

One person had already selected his five OJTs, and then sent them to SER to be certified. Of those five OJTs, one was in graduate school and close to his Ph.D., one had a B.A., and three were high school graduates. All were considered CETA eligible by the CETA program.

4. Needs of clients. When asked what the needs of CETA clients are, especially women, responses varied. Six said clients need more skills training, three mentioned child care problems, and one said transportation was a problem for his employees.

"The availability of jobs is the main problem," said one employer. One thought clients needed "pre-training on how to interview," and another said clients "need to realistic about their abilities."

5. Are clients needs being met. Employers did not seem sure that clients needs were being met, four thinking that CETA might be taking care of problems and one saying no one was solving the problems.

One said that CETA staff "never came to check" on their client until the end of the contract when they came to "find out if we were going to pick her up." But another employer said that staff came monthly to monitor while on the OJT," but added that the visit "was more of a formality."

6. More women involvement. When asked how more women could become involved with his business, one employer replied that he had

a "small business, with no facilities for women," and so was not planning to hire any. And another said he would like to expand his involvement but that he was "laying off people instead of hiring." Most employers gave noncommittal answers.

7. Success of CETA clients. All but one of the employers felt they had at least some success with the clients from the CETA program. And most felt that the CETA program was doing a good job. Two felt they were doing a poor job and two did not know.

One person who liked CETA said the program needed more publicity because it "could be fantastic, but if nobody knows about it, what good is it."

One employer praised SER, saying it does a "good job," but complained they had once hired a Vocational Technical CETA graduate who had taken the secretarial course. "She claimed she could type 50 wpm but could do only 25 wpm."

8. Expanding employer involvement with CETA. When asked how business could become more involved with CETA programs, one employer said CETA "should do more PR in the community." Another added that "businesses don't know about the OJT program," suggesting CETA should advertise it. And one said that "business should do more training" itself.

9. Continuing CETA involvement. A majority of the employers (7), were interested in continuing or expanding their involvement with CETA. However, one answered that hiring was "slow right now. We'll have more when we get busier."

When asked for other ideas, several employers advised the CETA program to do more advertising to business to make them more aware

of the program. And one employer advanced the idea of a program that was "part OJT and part classroom training."

E. ISSUES RAISED BY CLIENTS

Overall, clients interviewed seemed enthusiastic about their involvement with CETA. But, they did not seem to have a clear idea of the program and how it worked. They knew only what they had experienced themselves.

1. How clients learned of CETA. The clients interviewed were first asked how they learned about the Boulder CETA program or the women's grant project. Seven learned about the program from some type of advertisement, six said friends told them about the program, and five were referred by other agencies. Of these five, one came from ES, two were referred by Mental Health, one came from the Women's Resource Center, and one from the Vocational Technical school.

2. Why clients went to CETA. When asked why they went to the program, 11 answered that they wanted a job and six wanted some type of training. One person explained that she was "new in the community," and was having "difficulty finding a job." Another had been on welfare, and "wanted to get into the job market."

One woman said that CETA "was only one of many avenues I tried for employment." Another woman said that she came to CETA instead of ES because "I never considered ES as a place to go for help."

One person, signed up for the workshop offered by the women's grant, felt the workshop was "perfect for me." She explained that she already had job skills but needed "job hunting skills," such as resume writing and interviewing techniques.

3. Application. Most of the women (10), felt the application they filled out was reasonable. Three considered it unreasonable or unclear and two could not remember it. One suggested that the application should be bi-lingual.

4. Introduction to CETA. When asked about the introduction to the CETA program, one woman answered, "There wasn't any." Seven felt any introduction they received was not complete, four felt it was complete, and one could not remember.

One woman felt that "if there are a lot of things to know, we should be told about them." Another said that the "way information is given, you're not encouraged to come back." One woman in the women's project said of her first interview, "They didn't explain everything well because they were so busy interviewing everyone."

Two women felt they received a full explanation after they were already in the program, one explaining, "Someone called me after I was on my OJT to help explain the program and benefits I could get."

5. Counseling. Most of the women(8), felt the counseling they received was helpful, calling it "encouraging," and "supportive." But two thought it unhelpful, one feeling the counselor was "just putting in his time." Two women said they had no counseling.

6. Aptitude Tests. Ten women said they received no aptitude testing. But of the four who did take an aptitude test, three felt positively about it, one from the women's project commenting, "It was amazing; I found out I was correct in my career aspirations." One felt the test did not help her because it was not "relevant" to her needs.

7. Decision for training. Ten women felt they made the decision about the segment of the program they entered, while four felt the decisions were based on the class or job available at the time. One woman said she was "still on the job list waiting" for a job.

8. Explanation of job or training. Seven women felt they received a complete explanation of the training or job they were entering; four felt it incomplete. One woman said that "CETA should double check the sincerity of employers," because "there is abuse."

9. Clients feelings about CETA. When asked how they felt about their training or job, ten women answered that they thought it was a good experience, and two felt it was a poor experience. One said her experience was "really useful," and another praised the OJT program: "It especially helps people with no experience; it gives a company a reason to hire someone inexperienced and train them."

One person had a bad experience in a secretarial course, saying the Vocational Technical instructor "played favorites and intimidated the clients who weren't Anglo."

Another woman seemed to feel bitter about CETA, claiming, "CETA rewards those least likely to succeed," and adding, "CETA is stacked in favor of people who sit around and don't work and screens out those who are the working poor and motivated."

Of those who had completed their CETA involvement, seven had found jobs and two were still looking. The jobs they found ranged from a clerk making $350 a month, to a nurse earning $3 an hour in a doctor's office, from a woodworking machine operator at $2.95 an hour, to an intake technician making $683 a month.

F. NEEDS OF WOMEN IN THE AREA

The purpose of this section of the interview was to find out if women were content with their present job and to see if they had given any thought to their future possibilities in the job field. The results were disappointing. Most women were not satisfied with their present jobs but few had given serious thought to the future. Even if they knew what job they would like to do someday, they did not have specific plans mapped out to reach their ideal job.

1. Job History. The women were asked about the favorite job and the best paying job they had ever held. Best paying salaries ranged from a low of $2.95 an hour as a wood working machine operator to $14,500 as a teacher. Most of the best paying jobs were also the favorite jobs held by the women. These were varied: actress, speech therapist, production coordinator for TV, intake technician, and the more common jobs of receptionist, secretary, and teacher.

Most of these jobs listed by the women in both categories were held outside Boulder. The women found in many cases, that moving to Boulder meant a lower paying and less professional job.

2. Present job problems. Nine of the 18 women interviewed felt their present salary was inadequate. One woman said, "What's rotten is that there's no possibility of promotion." One woman felt her working conditions were poor and another had an abusive husband and was in family counseling. These all caused problems in their present work situation.

Six women had children and providing child care caused problems while they worked. Two had transportation problems and two said they had medical problems.

3. Ideal job. When asked what job they would like if they could arrange a hypothetical "ideal" job, all the women chose a job different from the one they were now doing. Even those who wanted to stay in the same field wanted a promotion or some expansion of their present job.

Some ideal jobs were more possible than others. One woman wanted to design clothes, have a boutique in Paris, and make $70,000 a year. This woman is now working as a sales clerk.

One woman may succeed in her ideal job. She wants to be a translator for a large international company. To accomplish this goal, she is working her way through school to obtain a degree in Spanish and only has a semester to go. She is a female head of household, with two school aged children.

One older woman had very low expectations and had difficulty imagining an ideal job. She finally said she would be satisfied if she could find "assembly work," where they would train her. She said she would enjoy this because she "likes working with people."

4. How to get ideal job. To get their ideal job, 10 women said they would need more training, either vocational or academic. Four said they needed more experience, one needed her GED, and one needed ESL classes. One woman said, "I have experience, I just need a job," expressing the view of several women.

In supportive service areas, three women said they needed child care to enable them to work, and one woman said she had transportation problems. She lived in Lafayette and had no car, but felt the closest place she could find a job was in Boulder.

5. Other employment needs. When asked about other employment needs, one woman answered, "Just making sure I have time to fix the meals and clean house."

6. Employment needs of other women. Finally the women were asked about the employment needs of other women. "A decent salary," said one woman, and another added, "Salaries are simply atrocious " in Boulder. Four felt this was an important need.

Another need was child care (mentioned by 7 women.) Besides needing child care after getting a job, one woman said there was a need for "a place to leave kids while looking for jobs."

G. SUPPORTIVE SERVICES

The staff was next asked about their supportive services, concentrating on five areas. One person admitted that supportive services "is a weak area." Another said of it, "It's available but not available."

1. Child care. Five staff said they referred women with child care needs to lists of day care centers. Four did not know what to do when women needed child care, but four said CETA has funds available. One person said, "If they are desperate, the program will fund for a week until they get money."

2. Transportation. When asked about transportation needs, one person said, "I give them a bus schedule." Three did not know how to answer the question and six said that CETA has bus tickets available for clients who need them. But one person added that the tickets "are available but rarely used."

3. Medical/dental. Two people did not know about money for

medical needs, six people said they referred people to health clinics, and four said that CETA pays for medical help. One explained that "if they really need it," clients can go to a doctor or dentist for help and "send the bill to CETA." But another qualified his answer by adding, "We try not to let on that we have these funds."

4. Mental health/personal counseling. Ten staff said they referred clients to mental health agencies when they needed personal counseling. The others could not answer the question.

5. Legal. Most staff (9) referred clients to agencies such as legal aid. One said, "I have friends who are attorneys if the clients can afford it," when asked how he helped clients with legal problems.

After interviewing staff, the research team obtained copies of the Boulder County Community Resources Directory, published by the Volunteer and Information Center of Boulder County.

Eight child care facilities or referral agencies were listed. There were 45 pages of health service listings. Under mental health were 12 listings, with additional listings under drug problems, alcoholism, emotionally disturbed, psychological services, and psychiatric services. Fifteen agencies were listed under Legal Aid agencies.

H. SUMMARY

Boulder was a site with a bright, educated staff with some good ideas and potential to be a dedicated CETA team. However, they now have little sense of teamwork or direction, and little coordination

of services. There seemed to be no clear line of authority for staff, either from within or without the program.

Boulder has an additional problem in the types of clients they serve. They serve two groups--the rural, minority, disadvantaged poor, and the young, Anglo poor who are willing to lower their standards of living to stay in Boulder. Unfortunately, the real disadvantaged, who often live outside Boulder, is the group that often gets left out.

The brightest part of the Boulder program is the Women's Significant Segment project. Even though they are separate from the main CETA program and are even opposed by some CETA staff, credit for getting the grant goes to the CETA program, as well as the Women's Resource Center. The women's grant staff members are enthusiastic, with some innovative ideas for serving women.

NOTES

1. Information taken from Boulder Comprehensive Plan for 1977.
2. From information received from Bob Harden, Fiscal unit, ETA of DOL, Region 8.

OPPORTUNITIES INDUSTRALIZATION CENTER

A. OVERVIEW

The City and County of Denver is the prime sponsor of the area and the Mayor is the head of this governmental entity. Denver Opportunities Industralization Center (OIC) is a subcontractor of this prime sponsor. Denver Manpower Administration (DMA) is charged with the responsibility for conducting the CETA program in the Denver County area. The Manpower Advisory Council (MAC), whose members are appointed by the Mayor, make recommendations to the Mayor for the overall strategy DMA should use in dealing with local CETA programs.

The City and County of Denver Planning Department's most current estimate of the population is 525,600 as of January, 1976. This figure is expected to decrease as more jobs become available outside the Denver area. The target groups and the percentages recommended by MAC for service in 1976 were:

Economically disadvantaged	90%
Heads of Household	70%
Women	60%
Men	40%
Chicano	50%
Black	30%
Anglo	16%
Other	4%
16-21	40%
22-44	52%
45+	8%
Targeted Veterans	5%

There were 2,706 persons served in FY 76 under Title I at a cost of $1,877 per placement.[1] The successful participant rate was 70%. There were no monies budgeted for supportive services except for transportation.

Other service needs were handled by referrals to other agencies in the area.

In addition to Title I activities, DMA also administered programs under Titles II, III, and VI. Titles II and VI, dealing with Public Service Employment, had 60 slots and 478 slots respectively in FY 76. Title III guaranteed that in addition to 2,700 summer youth, 100 accused felons in the Pre-Trial Intervention program would be served by DMA in 1976.

Under Title I, the following agencies were subcontractors with DMA for delivery of service. Opportunities Industralization Center (OIC), Jobs For Progress (SER), Denver Manpower Center (DMC), Singer Career Placement Center, and Freedom House Job Placement Center, The first four agencies provide a full range of services from orientation to placement, and the fifth agency provides direct job placement only.

OIC, located in east Denver, was chosen as one of the sites for in-depth study. This choice was made because OIC is a subcontractor with the largest prime sponsor in the state and because it serves a primarily Black population. OIC maintains two locations in the Denver area, one at Five Points Community Center, 2855 Tremont, and the other at 1301 Quebec. The first facility is used for intake and the second is for training and all other activities of the program.

In addition to its staff, OIC also has a Board of Directors and an Industrial Advisory Board. The members of these advisory boards represent community organizations, industries, business, educational institutions, public officials and interested citizens.

The major portion of the study occurred during the week of December 13 - 17, 1976. OIC at this time was negotiating a new contract

with DMA using a new Request For Proposal (RFP) system. A new director had been hired approximately two months earlier and this combination of events at the time of the study caused some problems in scheduling staff for interviews.

According to the OIC FY 1976 Project Plans Outline, 1,138 clients were to be recruited. Of this number 50% (569) were to be eligible for pre-orientation interviews with 40% (455) to attend orientation during the contract year. Actual enrollment was to be provided for 32% (364).

Because the educational level of most clients served by OIC is below high school level, an important feature of the program is pre-vocational, basic education. Two hundred and sixty-six clients were to be served in this activity during the contract year. Vocational skill training was to be provided, with clients being encouraged to participate in both activities as needed. At the time of the study clerical training was the only class in progress.

In FY 1977, OIC will receive funds totaling $406,998, with transitional quarter funds of $68,000.[1] The budget for OIC FY 1976 was $555,619 according to information provided in the FY 1976 Project Plans Outline which is a higher fiqure than that for FY 77.

B. SELECTION OF SAMPLE

A random sample technique was used at OIC as at all of the other sites to chose respondents for interviews. The agency's files were used to obtain 14 names of clients and eight employers. Of the fourteen clients, four were in classroom training, three had been placed in jobs, two were negatively terminated and five were in active job development. Twelve of the 21 staff persons at OIC and three staff of DMA were

interviewed. One staff person, given an abbreviated interview, is not included in the staff count but this information is included in the interview observations.

Four members of the two OIC boards were interviewed. Their comments are presented separately because their knowledge was more general and the intention was simply to gain their perspectives.

C. ISSUES RAISED BY STAFF

Two different program staffs are included in the responses. The staff members usually responded with information about the program where they were employed.

There seemed to be a degree of alienation and confusion, based on a lack of information, between the two staffs. Some of the OIC staff were cynical of DMA's commitment to the successful operation and continuation of their program.

1. Model for clients in program. The first question asked for a description of a clients entry and experience in the program. All 12 of the OIC staff persons intervewed could explain the process of clients' entry and experience in the program. The DMA staff members had more general knowledge of the entire prime sponsor program and knew little specifically about OIC.

2. Planning process in the area When asked to explain the planning process the answers were more diversified and detailed. Nine staff persons indicated that MAC was responsible for all planning. One staff member who felt that the MAC figured in the planning process "doubts how functional that body is," but another said that the MAC was "not a rubberstamp group."

Commented another, "The mayor is relatively informed of DMA

and its council but the authority of the Mayor is delegated."

One staff person "doubted that there was any community input," and another expressed the same opinion saying that women and the community had no input in the planning.

Three answered the question in terms of the planning at OIC and said the director and coordinators of the program made the decisions. Two other OIC staff persons said that they " do what they're told," and that the "planning done is effective because they make it effective."

According to two staff at OIC, "there are checks made around the community to see what courses people want," indicating that the community does have a say in the planning of the program.

Four staff persons said that they did not know what the planning process was.

3. Identification of general needs of clients. In response to the question of how the general needs of clients were identified, statistics were said by six staff persons to be the basis for identification of general needs of clients. One staff person said it was "probably based on meeting specifications set up of target groups by the CETA administration," adding that "programs must 'cream' to meet these goals."

Nine felt the staff defined the needs of clients based on an assessment of client forms and staff involvement in the community.

Political considerations were also said to be important in the decision making process. The Industrial Advisory Board was also viewed as significant in the planning process.

4. Needs of women clients. The next question asked for staff perceptions of the needs of women. Child care was identified twelve

times and transportation ten times.

Commented one staff person, "Lots of women still depend on sisters and others and this is sometimes unreliable," adding that transportation is also needed for getting children to child care." This staff person said that transportation to a child care location was more difficult than securing child care.

The fact that more job opportunities are located in outlying areas increases the need for dependable transportation according to another staff person.

Four staff commented that the female heads of household are especially in need of a wide range of services, of which child care and transportation are only two. Their most pressing need, according to these four staff persons, was for better paying jobs. The route to these jobs was thought by one staff person to be personal counseling and vocational training. These women were said to need a "sell yourself pitch," and to be "more assertive."

One staff member said that these women have "rusty skills" and "don't know what they want."

Another declared that training was secondary and that women need to look at non-traditional jobs. "We need more management OJTs" said this staff person; "most women are in a clerical rut."

5. Ability of program to meet women's needs. When asked if the program was meeting women's needs, seven staff said their program was partially meeting the needs of clients. "Trying to meet the needs but limited," was the description of one of these seven staff members.

Four staff indicated that their progam was meeting the needs of

women completely. Most qualified their statements by saying that they were doing all that was allowed under the contract limitations.

"I've actually seen it work," declared one staff person talking about the operation of the program in meeting the needs of women clients, adding that "the enrollee has to meet us halfway."

Another continued this assessment of the clients' role in having needs met, "Some people don't make any kind of effort and they drop-out." This person went on to say, "Paying people ruins people helping themselves." The provision for paying clients while they are in training was not viewed favorably by this staff person and others on the staff shared the same view.

6. Internal program evaluation. In response to the question concerning an internal evaluation system for assessing the effectiveness of the staff and program, 13 staff stated that there were weekly and monthly goals, and described this as a "very good" way to "keep the staff informed" of program progress.

Seven staff said that the staff receive regular evaluations. These evaluations are conducted by the component supervisors and the director. The Director of OIC was spoken of as a "for sure together guy" and credited with establishing new methods of evaluation.

Offered another staff person, "National OIC monitors the program every two or three months" and provides feedback to every individual staff member.

Evaluations done by DMA of programs were said to occur at the desk level using MIS data concerning planned versus actual performance. An Evaluation and Operations Manual is being prepared by DMA to facilitate this process.

7. DOL evaluation of the program. The next question asked for an assessment of the usefulness of the evaluation of the program by DOL. The majority of those responding, five, had no knowledge of such an evaluation and three did not respond to the question. None rated the evaluation as useful.

One comment offered was "DOL should be more concerned with wage level and retention and less with cost per placement."

Another observation was that the evaluation by DOL was "not too effective, they don't really look at the effectiveness of OIC," adding further, "if they did, we wouldn't have funding hassles" with DMA.

"Zip," was the summation of another, indicating that DOL's evaluation was non-existent.

8. Strong points of the program. When asked to assess the strong points of the program eight staff interviewed felt that training was the strongest point of the program. As one observed, "You can't take away a person's skills."

Three indicated that counseling was a program strength. The counselors were seen as knowledgeable about the program. Said one staff person, "Counseling is the best; they will sit down and talk to clients."

Two concluded that OIC is a strong community-based center that employers trust. The Industrial Advisory Board was seen as facilitating the establishment of positive relationships with employers.

Serving people who cannot go anywhere else because other agencies cannot or will not serve them was another point of strength shared by four staff members.

Although there was some dissatisfaction with the program expressed

by the staff. One added that he felt positively about "the potential of the program, versus it's reality."

The strongest feature of the program according to another staff person was the thorough assessment of clients to assure that they can make it through the program to successful placement.

9. Weak points of the program. The next question asked staff members to identify program weaknesses. Six of the staff expressed a desire for "measurable objectives per component" and "diversification of the program."

A staff person mentioned plans to keep the facilities open for evening activities as this was felt to be a way to more adequately use the facilities and afford more people the opportunity to participate in the program.

Another problem cited was the competition between agencies because of the emphasis on placement by DOL. "DMA says serve Blacks and this causes fights among agencies trying to get the correct number of Blacks."

One staff person stated that he was "not happy with the program now" and felt that both OIC boards were underutilized. Further, he felt that stipends had been detrimental to the program saying, "The self-help concept needs to be encouraged, we want to be seen as supportive." He added that the program is in the process of developing a motivational package to deal with this problem.

Another concern of one staff member was that money from other sources needed to be sought because of too much dependence on CETA.

Other suggestions for improving the program were that courses taught should be for shorter time periods because the length sometimes

was felt to contribute to the drop-out rate of clients.

Several staff mentioned that the turnover of directors recently had resulted in low staff morale and concern about the stability of the program but according to one staff member, this situation had become "much better."

10. Comments on CETA. Finally, the staff was asked if they had any comments to make about CETA. These comments covered a wide range of issues. One staff member expressed the opinion that CETA has been "tremendously undermined" by the recession which has caused umemployment for many skilled and educated persons who now come to CETA programs, pushing out needier groups.

A second expressed much the same view saying, "CETA serves fewer disadvantaged under Titles II and VI than it should," commenting further that "Titles II and VI are serving Anglo males too much and the long term unemployed need more help."

Another observation of a staff person was that cost per placement needs to be more flexible.

One staff felt that there was a growing federal and national push to return to categorical programs and another declared, "There needs to be better categorical decisions."

"The (CETA) law doesn't create problems because of its broadness. The problem is with interpretation," according to another staff person.

DMA in its application of the CETA program was seen by one staff person as "acting like they're working with robots," adding that, "they have no minority input." It was further added by this person that minorities are regarded by DMA as having "no skills" and not being "smart enough."

"CETA should be more consistent," observed one staff person who felt resentment because of yearly changes in the funding procedures.

C. ISSUES RAISED BY BOARD MEMBERS

The following information was gathered from board members that were interviewed. The same interview schedule that was used with staff was used in these interviews but the treatment of the data is different because the board members are not involved in the day to day operation of the program and in most instances the information asked for dealt with specific aspects of program functions.

The board members interviewed had a general sense of what the program provided. They all expressed interest in and concern for the program and wanted it to be successful. One board member said that he had been involved in teaching clients how to use money and another said that he had served as a conduit of information to OIC in the areas of training and employment. He further stated that he kept OIC aware of changes in the economy that could be considered for both immediate and long range plans.

One of the staff members of OIC shared that one board member had advised against proposed plans for a class to be included in the training program for participants because he knew there would be no opportunities for employment in that particular skill occupation. Layoffs in that occupation soon occurred, proving that board member correct in his labor forecast.

Because of business contacts, board members are also sometimes able to "open doors" to jobs for OIC participants. Board members have been instrumental in securing equipment and in raising funds for the program.

The board members addressed the issue of needs of participants. One board member said that the most important thing to him was that the participants learn to honor their commitments. Another board member, who had sat in on classes, said that from his contact with them he felt that they needed counseling on how to get and hold jobs, information on appropriate dress, and all other information concerning employment. He further stated that many participants were functionally illiterate and in need of basic education.

The needs of women participants, especially heads of household, were thought to be worse than those of men by one board member. "They need knowledge of what's available," declared one board member adding that supportive services also need to be "beefed up."

Two other board members said that they could not break out differences in the needs of women and men participants. One of these two elaborated and said that most women have "limited skills, limited knowledge, and lack of confidence."

The DOL/OIC relationship was seen as helpful "when DOL was directly funding it," according to one board member who when assessing the present relationship said, "Whoever controls the dollars controls the program." DMA was seen as "pulling in and pulling in, taking the authority and initiative of OIC away." This same view was shared by another board member who said, "The new setup is to get rid of SER, OIC and all categorical programs.

Even though categorical programs preceded CETA, a strong feature at OIC, as seen by two board members, was that ethnic control of programs serving the same ethnic group have a better chance of success. As one put it, "OIC does a better job of getting people and keeping

them."

Other strong features of the program according to the board members interviewed were new leadership, the ability to take care of school drop-outs, the ability to give participants personal attention and to relate to them, and continued contact with the business community.

The primary weakness of the program as identified by one board member was the need for additional sources of funds to allow the program to function according to its own plans. The only other weakness identified was that a better plan should be developed for determining the areas in which jobs would probably occur.

There were varied observations concerning the CETA law. One board member described it as "a political animal - as good as any." He concluded that "the system isn't going to change and you have to learn how to use it."

Another board member said, "If we tried to put a man on the moon the same way we run the Manpower programs, we still wouldn't have a satellite in the sky." He felt that millions of dollars had been wasted on federal programs.

One solution offered was the creation of a Cabinet level position to take over all the programs and establish specific nationwide goals. "Efforts are so fragmented in this country that tremendous energy and resources are wasted," concluded another board member.

One board member was critical of CETA and felt that most CETA programs "didn't know where they were going" and that DMA was "not predicting and planning for jobs that would be available"but "sometimes training when they knew no jobs were out there." Further, this board member felt that "CETA plans did not include services designed for women."

E. ISSUES RAISED BY EMPLOYERS

All of the eight employers interviewed seemed to regard OIC as a place to secure employees and that OIC provided reliable service. Equal opportunity policies in hiring may have been one reason for this acceptance on the part of employers.

1. Relationship with CETA program. The first question asked employers dealt with what their relationship was with the program. Four of the employers interviewed were at locations providing unsubsidized employment. Said one, "We won't get involved with federal funds." Two employers did not know that participants were employed at their locations.

2. Involvement with the program. The next question asked how employers had become involved with the program. Three employers said they became involved with OIC on their own initiative. One explained, "We decided to go in-house and train and called all Denver (training) schools. Three employers did not know the process by which their agencies became involved with OIC. Two responded that they were approached by OIC staff persons. "The staff came out first and opened the path," offered one employer.

3. Contractual agreements with the program. Five employers said they had no agreement or contract with a CETA program and three did not respond to the question.

4. Definition of positions and responsibilities. All eight employers decide and define job responsibilities at their sites. One employer said job descriptions were also filed with the ES office but that to date he has received "not one call from them."

5. Selection of clients as employees. When asked how participants

were selected at their locations, seven employers stated that they made all selections. One said, "If their appearance is poor, they don't get applications or interviews." One employer did not know how the selection of employees was made.

6. General needs of clients. In response to the question concerning the general needs of participants, three felt that the participants lacked communication and interpersonal skills. As one expressed it, "Some can't relate or take supervision."

Three employers said that skill training was needed by participants. One of these three employers assessed client skills as "minimal" but added that the "job doesn't require much."

Immaturity and lack of responsibility were cited by two employers in assessing the clients as employees. "They quit without notice," observed an employer.

Child care was seen as a need by two employers. As one employer put it, "Sick kids are a problem, but those women work hard even if their priorities are at home." Another employer who did not see child care as a need felt that participants should be told, "Don't bring your children with you when you come to apply for work."

Educational levels of clients did not seem to be of concern to employers with only one indicating that it was a need. This employer said, "High school graduation doesn't matter for most jobs, but they must have it to advance to management."

Another employer said that all "applicants go together" and the needs of OIC people were not looked at separately. Neither women nor OIC participants were viewed as having needs different from other employees. When asked about the needs of OIC women participants

specifically only one employer responded, stating that women clients "couldn't lift" heavy machine parts for cleaning.

7. Are needs being met. When asked if the needs of clients were being met, five employers felt that they were not. Lack of follow-up was the most frequent answer given for this deficiency. Said one employer, "Participants aren't followed-up except at four days after placement."

Another employer felt that the OIC staff was meeting the needs of participants and described the OIC staff as being "very sensitive to the needs of clients."

The work attitudes of participants were of concern to another employer who suggested that the OIC staff should coach the participants on correct behavior at the job location.

8. Greater women employee involvement. When asked how more women could become involved in positions in their businesses, five employers said that all the employees were women now or predominately so. One woman employer said that the women who had applied where she worked "weren't as sharp as the men" and another employer said he had no aversion to hiring more women. Said one employer, "If they are from OIC, we hire."

9. Affirmative Action Plan. Four employers said there was no Affirmative Action Plan at their locations. Of the two who said they have such a plan, one said he "has had 50% colored" and "resents" the rules and supervision. One employer stated that he "thinks Civil Rights people expect him to tolerate thievery," adding that since there are "no Spanish in the neighborhood" he has "no requirements there." One employer did not respond to this question.

10. Success of participants. Of 29 participants that were known to have worked at these locations, six employers felt that they had had some success. No opinion was expressed by one employer and another rated the participants as having had no success.

11. Effectiveness of program in assisting clients. Concerning the employers' experience with OIC and evaluation of OIC's effectiveness, four employers said from their limited knowledge, the program seemed to be effective. Two employers indicated that they did not know enough about OIC to evaluate and one rated the effectiveness of OIC as poor. OIC is "good at what they do," one respondent offered, adding that there is not good follow-through.

12. Increased involvement of other businesses. In responding to the question of how the business community could become more involved in working with employment and training, two employers did not respond at all. One felt that OIC should "approach them," also stating that the staff should get employer listings from ES.

Another view was that "we could save millions of bucks if we could get these people off welfare and make them independent." This observation was from the same employer who viewed his business as having had no success in dealing with participants and expressed resentment of Affirmative Action policies.

One employer shared the idea that child care needs of women should be given priority and attention at the time of hiring.

13. Increased involvement of present businesses. When asked if there was interest in expanding the involvement of their agency with OIC, five said yes and added that they were open for employment of other participants. Two qualified their responses with a suggestion

for "better screening" of applicants referred. One employer said he hired people for specific jobs and said that the source of such an applicant was unimportant. There was no response by one employer.

14. Other ideas concerning OIC. The employers were asked for any other ideas about OIC and its effectiveness. Six comments centered around the issue of stressing appropriate behavior and dress for work to clients. Said one of the six employers, "Clients should learn to be an asset, not a liability" to the companies where they are employed. Two employers were concerned "with the unrealistic goals of clients and their not wanting to start low and work their way up." One other employer said he didn't know what had been tried by OIC and felt that he could not suggest any specific changes.

F. ISSUES RAISED BY CLIENTS

The 14 women clients interviewed were generally satisfied with their experiences in the program and felt that the experiences had been worthwhile.

The major concern of the women seemed to center around classroom training. There were questions concerning instructor/student relationships and the length of the scheduled classes.

1. How clients learned about the program. The women were first asked how they learned about OIC. Nine of the women learned about the program from friends and relatives. Four said they heard of OIC from the program recruiter. One of the four said, "I was in the Food Stamp office and a guy outside the door was recruiting." Two learned of the program through the media.

2. Why clients went to the program. When asked why they went

to OIC, eight women said they went to OIC seeking jobs and the same number, eight, said they wanted training. As one woman said, "I wanted a skill to get a better job." Two other women said they went to OIC because they knew that OIC paid a stipend for those enrolled in the program.

3. What happened to the women at OIC. The women's responses about what happened to them when they went to the program varied. Eleven women indicated that they received the full range of services provided at OIC. The time lapse between application and subsequent services ranged from a couple of days to a number of months. The average amount of time between application and the other activity was two weeks.

Two women said that they did not receive full services. "I went to part of it and got married and left," was the reason for not receiving full services offered by one woman. Another said she "never received the training desired," but was sent for an interview for a job at a cafeteria. She did not accept the job and is still in active job development.

4. Written application. When asked what they thought of the written application, two women stated that they had found it unreasonable. One woman needed the help of her mother to fill out the portion dealing with income. The other woman said she was on AFDC at the time and "not very happy with her life." She found the application "depressing."

The other 12 women found the application reasonable.

5. Introduction to the program. Twelve of the women interviewed felt that their introduction to the program and services was complete.

On being selected for jobology, one of the OIC program components, one client said she "felt a whole lot better."

Of the other two women, one did not respond to the question and the other felt that her introduction to the program was incomplete.

6. Counseling. In response to the question of how they felt about counseling, 12 said that they found counseling helpful. "They did a beautiful job," offered one woman and another said, "They didn't nag; they made me feel important" and encouraged me to "have a positive attitude."

Two women said that they could see the counselors as often as they wanted even though there were scheduled counseling sessions for clients every Friday.

The counselors were said by one woman to "take an interest" in the clients and to "try to find out what personal problems they had holding them back from doing a job." "They were sure for me and wanted to help me better my condition," offered another woman.

Counseling was also seen in less positive ways by some women. Three women thought that the counseling was "repetitious" and at the level of "friendly conversation " that was not helpful. One counselor was said to "never do what was promised." Another comment of one of the women was that one of the counselors could not solve problems and had problems communicating with clients.

7. Aptitude tests. The next question asked was how they felt about aptitude tests. Five women said they did not take aptitude tests. Five other women who took a test felt the tests were a positive feature of the services they received. As one woman said, "After taking the test, I knew where I stood." The tests were said to be helpful

to teachers to indicate the areas the women needed more help in. These tests were said to be most useful for those women who had no skills.

8. Decisions for placement. Next, the women were asked how the decisions for their placement was made. Nine of the women said the decision for placement was their own and the counselors provided information to facilitate them with the selection.

Four of the women said that the choice was made based on what was available at the time, explaining that courses at OIC begin when enough participants are enrolled in the class. There are schedules for these classes and participants who enter the program after classes have been in progress can either wait for the next session of that class to begin or take another class if one is available.

9. Explanation of training. When asked what they knew about the training before they started it, nine women interviewed said they had received a complete description of the training. Three qualified their answers for various reasons. One woman said what she was told would happen never happened and another woman said there was some confusion about the length of time for training. A third woman, who was referred to DMC for training as a barber, had to pay for part of the course since it extended beyond the six month contract she had signed. The course was for eight months' duration. This woman said she was not given this information at the time she entered training.

10. Program completion. Nine women, responding to the question concerning whether or not they had completed their training, said yes. Three other women were still involved in training.

11. Clients feelings about the program. The women were next asked

what their feelings were about the program. Eight of the women said they had learned in the classes in which they were enrolled. One woman shared her experience of increasing her typing speed from zero to thirty words per minute. Another woman rated her class as being "very thorough."

Five of the eight women who indicated that they had learned from their classroom training felt that the length of time provided for classroom training was too short and should be extended.

Only one woman regarded the training as a negative experience. "It wasn't worth my while, I didn't get anything out of it," said this woman.

Another woman, in addition to disagreeing with the length of classes, questioned the ability of one of the teaching staff. "In my class, everyone flunked," she said. Another woman said that the instructor "responded to some students more than others," and this "influenced how much the students learned."

12. Job success after program involvement. Five women said they had found jobs since training and five women were still looking for employment. One woman said she was not looking for work because she was returning to school.

Successful placement on a job was attributed to the efforts of OIC by three of the women. One said that she had secured employment on her own.

The fifth woman said that she had been placed in a job by WIN but that she had quit because it was too strenuous.

Four other women were in OIC's active job development component.

G. NEEDS OF WOMEN IN THE AREA

Interviewees were generally in jobs that did not have much or any potential for advancement. There were few benefits connected with the jobs but most of the women saw their present employment status as permanent. The needs that they identified were those that women in employment usually have: child care, transportation, and benefits that would provide a greater measure of security.

1. Job history. The first question asked for employment information, past or present, and salaries earned. The salary range of the women interviewed was from $1.90/hour to $900/month. Four women said they had never had good jobs. The woman earning $900/month was referred to her present job by OIC. After successfully completing the training period, at $3.75/hour, she was hired as a permanent full time employee. Said this woman, "I owe that to OIC."

Two other women had limited employment histories. One had had only one job and the other was in her second day of employment.

A third woman, who worked as an assembly person in a factory at $3.00/hour, chose that as her best job because she enjoyed the people she worked with and found the salary acceptable.

Tutoring for a school district in another state was the favorite job of a fourth woman. The salary for this position was $1.65/hour and was not the best paying job this woman had ever had.

2. Present job problems. Next, the women were asked to assess the problems they had connected with employment. Eight of the women felt that their salaries were inadequate. Five women said that they did not find their work satisfying or rewarding. "I had to take breaks to break up the boredom," stated one woman.

Work conditions were cited by four women as being poor. One

of these four women indicated that a male supervisor at her place of work was causing women to quit. No details were given of this situation.

A woman who spends three hours a day traveling to and from work by bus felt that transportation was a problem. This view was shared by three other women.

A WIN placed woman had injured her back at work and was in need of medical attention. This woman was certified as being unable to work and said that she was getting the "runaround" from Vocational Rehabilitation.

3. Ideal jobs. Next, women were asked what ideal job they would like to have and thought that they could do. Two wanted to remain with the same employer and advance within the company.

Four women wanted secretarial or clerical positions. This was seen by one of these four women as a "decent job" that would afford her the opportunity to "sit down" while working.

One of the women wanted a non-traditional job as a barber. She had just finished this training and was very pleased with her choice.

Only one woman said she would rather not work and she immediately said that she realized that that was not an option.

Some of the ideal jobs these women selected were fashion consultant, working with retarded children, and reservationist with a major airline.

4. How to get the ideal job. When asked what they thought they would need to get the ideal job, nine women felt that vocational/skill training was needed in order for them to get their ideal jobs.

Child care and flexitime were interrelated needs mentioned by two women who wanted their job schedules to conform to their children's needs.

Two women wanted financial planning assistance and aid to enable them to return to school while two others felt they needed personal counseling.

Legal help was needed by one woman who was involved in divorce proceedings.

5. Employment needs of other women in the area. The women were next asked to identify the needs of other women in the area. Seven women said that child care was the major need of other women in the area and six women said the greatest need of other women was transportation.

There was concern expressed for older women and the lack of a special program for them. Personal counseling and skill training were cited as additional needs of these older women and other women in the area by two women interviewed.

"If you haven't worked for a long time, you need to know how to dress and act at an interview, said one woman adding that "women need more confidence and motivation."

High rents and housing problems were also needs identified by two women.

H. SUPPORTIVE SERVICES IN THE AREA

OIC has limited means of funding services in response to the needs of clients. According to their contract as subcontractors to DMA, they can receive funds to provide transportation for clients while they are in training. OIC is dependent on referrals to satisfy most needs of clients and the success of clients depends, to a degree, on the effectiveness of the referral system. The staff was asked how needs of clients were satisfied in the following areas:

1. Child Care: Five staff persons gave the names of an agency they use in referring participants with child care needs. Two of the five knew that these agencies had sliding scale fees available. Concern was expressed by one staff person that participants with low incomes could not get help from Social Services. Many low income people are just above poverty guidelines and therefore are not eligible for needed benefits. Lists of day care homes available from Social Services were said to be used by three staff to either refer clients or secure needed information for the clients. Of the three staff who indicated they used referrals, one said they were not up to date. The intake counseling staff was said to be able to handle most referrals. Three who acknowledged that they were not aware of the referral procedure indicated that this was the responsibility of the counseling staff.

2. Transportation: OIC has an arrangement with RTD to purchase bus tickets at discount prices for students in training. Six staff persons declared this was their solution for transportation problems. One staff person mentioned a small fund that can be used for this purpose. Attempts are also made to establish car pools and in some instance staff cars have been used. Another staff, in responding to this issue, said that in DMA job readiness means that needs are not a problem, when often supportive service needs were still present.

3. Medical and Dental Needs: Both Denver and Colorado General Hospitals are used for medical referrals, according to one staff person. Neighborhood health centers are also used as referrals by six staff persons. Sliding scale fees are also available at these locations. Medicaid was mentioned by one staff as a solution for medical needs. Some money is available for medical and eye examinations through OIC non-CETA funds.

4. Mental Health: One staff person said the attempt is to "tap the resources in the community." Another said that "OIC can't help really serious problem people." The counseling staff tries to help participants with minor problem, according to one staff person, and others are referred to neighborhood mental health clinics. Vocational Rehabilitation is also used as a resource by the OIC staff for some clients.

5. Legal Needs: This is a need one staff person said the program "hasn't had to deal with too much." The Legal Aid Society was used by six staff members. One said that mini-courses are held for staff to become aware of legal services available to CETA clients. Another said the OIC policy is to not accept participants into the program who have trials pending. If clients have legal problems after being accepted by OIC, OIC will try to support them in any legal situations, said one staff.

The Community Services in Metropolitian Denver resource directory issued by United Way was mentioned by four OIC staff as a source for referrals.

The section dealing with child care lists 74 agencies. The service is broken down into five categories: daycare, emergency baby sitting, financial assistance, mutual care homes, and preschool. Each individual listing provides information concerning area served, persons served, hours, services offered, and information for contacting the agency.

The other services included in the supportive services part of the interview schedule have like descriptions. In the information and referral section of the directory there are 66 medical, 16 dental, and 37 legal references listed There are 11 pages dealing with

health agencies included in the directory. The health section is divided with specific sections, each dealing with a particular medical need.

Listings in the counseling section have 139 indices for personal counseling. There are seven other types of counseling in this section.

A second directory available is the Colorado Women's Resource Book. Forty-three areas of need are identified with available resources listed by geographical area. This book was published in October, 1976 and may be a source of more recent listings.

I. SUMMARY

There appeared to be a level of friction between the program and DMA. There was concern expressed by some staff members about the financial future of the program. The CETA funding of the program was higher in FY 76 than in FY 77.

The program staff seemed to be aware of the need to secure additional sources of funds. This would allow them to have more stability and also to be more creative in providing services.

There has been significant staff turnover and some staff said that staff morale was low.

Some of the staff members said that there was a need to improve both the quality and variety of classroom training.

OIC is accepted in the community which they serve and provides services for those that have trouble securing training from other programs.

The boards that serve the program, especially the Industrial Advisory Board, are an important feature of the program. They provide guidance and information to the program.

Finally, the new director of the program was said by the staff to be extremely competent and have the ability to improve and strengthen the program.

NOTES

1. Taken from the Comprehensive Manpower Plan FY 1977, page 13.

BETTER JOBS FOR WOMEN

A. OVERVIEW

Better Jobs For Women (BJW), located in Denver, is a CETA project administered by the Young Women's Christian Association (YWCA) of Metropolitan Denver, This project was begun in March,1971 during the time of MDTA and is now in its sixth year of operation. The project is funded directly from the Department of Labor, using Secretary's Discretionary Funds (Title III) through the Office of National Programs as an "Apprenticeship Outreach Program." The current contract is for BJW's FY 1976 only. The program will service the Denver Metro area. The program budget is $100,000.00.

In 1977, BJW's goal is to place a minimun of 100 women in apprenticeship programs and in the skilled trades and crafts occupations. The jobs developed will provide training and scheduled salary increments that result in middle income salary within a specified period of time.

The total delivery of services, with the exception of supportive services, is handled in-house. Supportive services are generally referred to other agencies in the area. There are some funds to supply child care and transportation for clients going to job interviews. In addition, there are funds for trainee supplies such as training and tutoring materials.

Those selected to receive priority are minority women, female heads of household/female heads of families, and unemployed, underemployed and economically disadvantaged women. All women selected must be qualified physically to handle the jobs in which they show interest.

The staff is composed of a project director, assistant director/job specialist, recruitment coordinator/counselor, instructor/tutor, and administrative assistant. All the staff members are expected to share functions and responsibilities of the program regardless of the position titles. Further, all personnel policies are in accord with YMCA personnel policies.

The staff, to secure placements, works closely with local Joint Apprenticeship Committees(JACs), the Colorado Apprenticeship Council, labor and management, Region VIII Bureau of Apprenticeship and Training and any other related employment and training channels.

The components of the program are mostly the same as those offered by other CETA programs but are modified to fit the uniqueness of the BJW program which is not under any prime sponsor.

Group orientation is held at the BJW office twice weekly, with one daytime and one evening session. During orientation interested women are exposed to the experiences of women working in non-traditional situations. A slide presentation, created by the staff, shows women placed by BJW at their work sites and gives a realistic view of the problems encountered by women trying to break into non-traditional fields.

Follow-up is done monthly or as needed and includes both past and present participants.

A monthly newsletter, with a supplemental portion devoted to current listings of community resources, and a brochure are distributed to participants, employers, and others who have asked to be placed on the BJW mailing lists.

The site visit occurred between February 1 and 9, 1977.

B. SELECTION OF SAMPLE

The selection of client and employers for interviews was done by a random sample technique. There were approximately 600 clients and 71 employers on file. The BJW staff participated in the selection by supplying phone numbers and addresses where the participants could be contacted. The research staff was not allowed direct access to the files because of BJW's policy of confidentiality of all records. The research staff drafted a letter, which was approved and signed by the BJW staff director, that was sent to all participants selected for interviews explaining the research and promising confidentiality.

Twelve clients, some of which had participated in orientation only, and eleven employers were interviewed. The entire BJW staff of five was also interviewed.

C. ISSUES RAISED BY STAFF

Overall, all the staff understood the total program. There seemed to be no lack of communication and interaction among the five staff, allowing the program to operate smoothly and effectively.

1. Model for clients in program. When asked about the experience of a client in the BJW program all five staff had complete information concerning what happens to clients from entry to placement. Each staff member is responsible for a specific function and shares the responsibility for other activities, according to one staff person interviewed.

2. Planning process. The next question asked for an explanation of the planning process. Three staff did not respond to this question. One staff was able to give a full explanation and another understood the planning process partially.

One problem that was seen by one staff person was that other CETA

programs in the area send over "all women" without screening to see if they are interested in non-traditional jobs. Since the BJW concept is for placement in non-traditional occupations, they are unable to serve many women who are referred to their program.

3. Identification of general needs of women. When asked how general needs of women are identified in the program, one staff person said that they use the same criteria established by CETA, adding that they have minority and heads of household priorities locally which match DOL national priorities. She further stipulated that there are no quotas for any group but that local preference is given to heads of families. Heads of household are seen by the BJW staff as different from heads of families in that heads of household are often single persons.

"All women are economically disadvantaged," was the view held by the BJW staff when discussing the needs of women. Three staff persons thought that child care was the most pressing need of women.

Two other staff cited the need for career counseling/exploration and an understanding of labor market procedures as an important need, stressing that without this type of information women cannot make realistic choices among existing employment opportunities.

Another staff person said women lack knowledge of the non-traditional occupations, giving an example of a client who "thinks bricklayers build fireplaces in people's homes," a very limited part of the skills necessary for this trade.

Location on a non-traditional job site can be an "isolating and alienating position to be in," noted one staff person, citing the need clients sometimes have for the on-going support of the staff.

"Strong advocacy" to obtain employment or training, orientation to "unionism" and knowledge of grievance procedures at work sites were other needs identified by members of the staff.

Because all the jobs secured by BJW are unsubsidized, there is often a need for books and tools that the women sometime can not afford before they receive their first paychecks.

"Displaced homemakers have been through everything by the time they come to BJW," offered one staff person. She continued, "They need personal counseling for non-traditional jobs." "Most older women lack the confidence to try for non-traditional jobs," was another assessment.

4. Ability of program to meet women's needs. In response to the question of whether or not BJW was meeting the needs of women, all the staff agreed that they needed additional staff and an increased budget but felt that they were doing a good job within these limitations. "Things are doing as well as can be expected," replied one staff person, "given that there is limited staff and money and overwhelming problems."

Support groups to help meet needs were being planned by the women in the program who will have the responsibility for their leadership.

Clients are coached in how to approach test situations and told what to expect during the test. Tutoring for tests and knowledge of specific skills are a part of the services provided by BJW. The clients are instructed in how to take aptitude test in order to have the tests reflect abilities that they want highlighted.

BJW also facilitates other agencies and groups all over the country who want some directions about how to go about establishing

similiar programs. The staff has prepared packets of materials that they make available to those who request this type of information.

Working with clients on a one-to-one basis is another way that the BJW staff tries to meet the individual needs of clients. They "care about their clients," observed one staff member, and try to insure that the clients know it.

5. Internal program evaluation. The next question asked whether or not there was an internal evaluation of the program. All of the staff indicated that there was such a system but one of the staff said it was "no sophisticated system." When asked for further information on the system, two staff said that the director was the appropriate person to answer that question. Two other staff persons said that data kept on retention rates and follow-up are used for evaluation.

"A lot of evaluation is establishing rapport with a person so they feel free to call when there is a problem," was a comment offered when asked about features of the program evaluation.

Another staff person said that there were monthly reports of program activities that are used for evaluation and that functional statistics are kept for use in making plans for reporting to DOL and for evaluation.

6. Relationship between program and DOL. Two staff indicated that they did not know what the relationship was between their program and DOL. Two others said they knew that DOL was the funding agency and felt that they were "helpful." Another said that the DOL staff visits their program monthly to check invoices for allowable costs.

7. Effectiveness of DOL evaluation. When asked about the usefulness of DOL evaluation of the effectiveness of their program, one staff person responded that DOL is very supportive of the program and has

been very helpful with needed information and directions. Three staff persons said they were not familiar with or did not know of DOL evaluation processes. One shared that her information was limited to knowing that monthly financial reports were made to DOL.

8. Strong points of the program. In response to the question asking for strengths of the program, the primary strength of the program as offered by one staff person is that, "BJW is unique in the area and answers a specific need." Another said she "thinks we're doing the job we're supposed to do, giving women information to make intelligent choices."

"The program says to people, it's your job choice, you carry the weight and we're available for support," was the way one staff person described the philosophy of the program and it's strength.

A further assessment was that staff members "are not shy about giving EEOC (Equal Employment Opportunities Commission) information to employers."

Tutoring, especially in math, referrals, placements and a 78-80% retention rate were said to be additional strong features of the program.

9. Weak points of the program. In response to the question concerning program weaknesses, all five of the staff said there is a need for additional staff and money to strengthen the program. The lack of adequate funds prevents the staff from providing a comprehensive referral system for supportive services in the area. As one staff person expressed it, "We're not effective liaisons always."

Follow-up was another area specified as needing improvement

by a staff person who explained that due to the demand on the time of the staff to insure that the program was functioning adequately, there is not always time available to visit job sites and clients as frequently as may be needed.

10. Comments on CETA Four of the staff had no knowledge of CETA law. The other staff person pointed out that BJW is different from most other CETA programs: "We're a special breed." She further stated that "we buy the concept of CETA" but went on to raise some issues concerning CETA, feeling that CETA serves male heads of household and male veterans best. She felt that there is a need for prime sponsors to build special programs with a different orientation and job development goal to answer the need of certain groups, such as women.

In addition, her assessment was that women do not always ask what services are available but programs should offer a full range of services to them anyway.

D. ISSUES RAISED BY EMPLOYERS

All the employers interviewed expressed support for the BJW program. Some of the reasons were for the benefit of the employers who were concerned with equal rights issues in hiring and felt the need for such a program as BJW.

1. Relationship with CETA program All program relationships with employers were for either unsubsidized jobs (10) or for union apprenticeships (1). The union apprenticeship opening occur infrequently, usually once a year, and sometimes outside the Denver area. An attempt was made to learn the number of positions available at each location and the number of those positions that were filled

by women. "I don't know, but numerous," was a typical answer of employers.

2. Involvement with program. Five employers said they established initial contact with BJW. One said "the compliance officer offered BJW as a place for women," adding that the compliance officer "thought we needed women." "BJW ran us down," was the observation of another employer.

Other employers, usually new to the job, were not sure how the relationship began.

3. Contractual agreements with BJW. Because BJW deals only with unsubsidized jobs, there are no formal agreements or contracts with employers.

4. Definitions of positions. The employers make all decisions in defining job responsibilities. Job descriptions are sent to BJW and they in turn send out applicants to interview for the positions.

5. Selection of clients as employees. In response to the question of how the clients were chosen for employment, all employers agreed that they made the selection of clients for hiring.

One employer said, "I send criteria for jobs to BJW, then they screen and send over applicants. Another employer shared that the interviews are "open to see what they're (the applicants) are like." He further shared that he lets the applicants "work awhile to see if they can do it."

The procedure for hiring at another location was the applicant first filled out the application, then toured the job site, and finally had an interview with the personnel officer before an actual opening was developed and offered.

"We had a hard time selling the idea to supervisors," offered one employer adding that the placing of women "required politicking with the staff." Another employer said he required "good strong physical specimens" and that the women had to know how to deal with "sexual passes from the men."

6. General needs of employees. When asked what the needs of clients were three employers said there was a need for GED, ABE, or ESL because of the need to read instructions.

One of these three employers said that "lesser skills meant better retention." This employer meant that jobs available to unskilled and educationally limited people were generally of entry level with no future and that the people in these jobs usually tried to keep them because they could not compete for more demanding jobs.

Four other employers felt that the women did not have adequate physical strength and were not reliable.

The opinion of three other employers was that there were no problems at all that they were aware of.

There was a requirement at one location that employees be able to go through 20" openings between equipment. An employee who could not meet this requirement was considered "too fat to work there."

"I have lost some women because of child care needs," offered one employer, adding that "most of the women are divorced or single," and may be heads of household.

Another employer assessment was that, "Everyone has to solve all problems before work begins. No concessions are made to women with children."

7. Needs of women clients Eight of the employers saw no difference between the needs of women and men. Of the three remaining, two felt hours, especially rotating shifts, may be a problem for women employees.

One employer acknowledged that there was some conflict between the men and women employees and that his business recognized the problem and had "had to put the skids on."

8. Are needs being met. In speaking of the ways needs could be met one employer suggested that those seeking apprenticeship programs not available in the Denver area should "transfer to states that have openings."

Another employer said he meets with all employees monthly and maintains close contact with BJW.

Finally, a employer responded that he makes an effort to counsel recently divorced employees and makes referrals to community agencies but he added, "I've never been married so there's a lot I don't understand."

BJW was spoken of as being "like us" by one employer, and having a hard time screening applicants to send over only good workers. "I don't know what they could do differently," he said.

9. Greater women employee involvement. Employers were next asked if they wanted more women employees. Four employers shared a common concern. As one of these four employers expressed it they are "trying actively to recruit more women for AA reasons.

Lack of experience and technical background were given as reasons by three employers for being hesitant about hiring women even though they indicated that they intend to hire more women.

Three other employers indicated that they prefer women to men

as employees. "Women are more interested in the quality of work than men," was the assessment of one employer. "They have a better eye," he added.

An assessment at one job location by an employer was that "we practice equal employment opportunity; always have." He added that supervisors are traditional and think women belong in the home. "We've got old attitudes to overcome."

10. Affirmative Action Plan. The next question asked whether or not there were AA plans at their locations. AA plans were in effect at five locations visited.

One employer indicated that his agency would do "what the law required," adding, "but it's difficult."

11. Success of BJW placed employees. In response to the question of how successful the participants had been only one employer viewed the BJW placement as being unsuccessful. The reason given for this was that the participant had the skills for the job but was "besieged" with personal problems.

The other ten employers interviewed felt the BJW participants were successful but cited some problem areas. One employer said there were problems with poor attendance by the participants and that some married women employees are "hassled by husbands" over long work hours.

Another employer said that one of the participants was a "strong girl" and expressed a desire to hire more "gals" like that.

12. BJW effectiveness in assisting participants. BJW's effectiveness in assisting clients with training and employment needs was viewed positively by eight employers. "Good effort" and "effective for blue collar women" were some of the comments offered.

The BJW referrals were said to have a good attitude toward work and two of the staff were described as "super."

Follow-up and selection of participants for application were viewed as "excellent."

13. Increased involvement of other businesses. The employers were next asked for their opinions concerning the involvement of other businesses. Of the 11 employers interviewed, four thought that the business community was unaware of BJW and felt that the program should concentrate on making itself better known.

One employer said that his business was willing to place and train women if they were capable of doing hard work.

Another employer offered the view that the "biggest thing that will help is women proving themselves in the job" adding that at first, "they have to do better than everyone else."

14. Increased involvement of present businesses. When asked if their companies were interested in expanding their involvement with the program, one response was "Oh, my gosh yes. We need qualified people." This employer felt that the "best employees are divorced women with two kids - they come to work."

Another employer stated his plan to list openings with BJW because "it takes pressure off me to find girls."

"We're pleased with the results," said one employer who also shared that his agency had "brought a few of the women along."

Another felt that the present level of involvement was working well and that BJW was there when needed.

15. Other ideas concerning CETA. Some of the employers had ideas

concerning the program. Some employers felt that BJW should send over trained clients, provide employers feedback, and give clients specific information when they go for interviews.

It was suggested that BJW secure lists of federal contracts, contact those holding them for additional placements, and investigate non-union residential construction companies for AA compliance.

One company has a policy of providing a tuition refund for those employees who have been with the company for one year and need skills upgraded for promotion or to maintain their present jobs. Profit sharing was the plan of another agency and a third saw merit in providing one-to-one conferences when working with employee problems. These features were felt to be important and the types of things BJW should look for in work situations with agencies when job developing.

The fact that more women are seeking non-traditional jobs on a larger scale was attributed to BJW's influence.

E. ISSUES RAISED BY CLIENTS

The clients interviewed were of two distinct groups: those that had been enrolled in the program and those that had attended orientation only. This accounts, in part, for some wide variations in clients responses to questions.

1. How clients learned about the program. Seven of the clients interviewed learned of BJW through friends or relatives. Three clients were referred to BJW from another agency and two learned about BJW through the media.

2. Why clients went to BJW. When asked why they went to BJW the majority of the women interviewed (8) said they went to secure

employment. Two wanted training and two others wanted counseling and aptitude evaluation.

3. What happened to women at BJW. The women were next asked to share the experiences they had when they went to the BJW office.

Orientation, a slide presentation and an interest inventory form were received by ten women. Of the ten interviewed, seven women called back for an interview and further services.

Specific apprenticeship positions were requested by two other women but there were no apprenticeship openings when they applied.

4. Written application. Next, the women were asked how they felt about the written application of the program. Nine women rated the application reasonable and the other three women interviewed did not remember the application.

5. Introduction to the program. In response to the question concerning the introduction to the program, eight women felt they had a complete introduction to the services and training available.

"BJW can only get me started, then I have to do the rest," was one comment offered.

Three other women interviewed felt that their introduction to the program was incomplete. Said one woman, "It left me feeling too old for most jobs; other jobs took a lot of training." This 55 year old woman wanted to secure a job as a truck driver and doubted that she would be acceptable as a trainee. She never asked questions of the BJW staff and did not pursue her choice, nor did she return to BJW after attending an orientation session .

Another woman wanted upgrading in a traditional position (secretarial) which BJW does not provide. She felt the slide presentation was too negative and said there was no opportunity to

ask questions during orientation.

The third of the three women who felt that their introduction to the program was incomplete said, "The program needs to help women without career goals, not hand them a book to pick out a job." She further stated, "Women need help in where to start."

6. Counseling. The next question dealt with the quality of the counseling the women received. Seven women interviewed did not indicate how they rated counseling, or said that they had received none. Three others felt that counseling had been helpful. Some comments shared were "fantastic" and "BJW has done everything imaginable."

One woman said she had talked with a counselor who promised to call back and never did. She did not find the counseling helpful.

7. Aptitude tests. The women were next asked how they felt about the Trade Interest Inventory given by BJW or any other aptitude tests that the program had provided. Four women said they did not take any aptitude tests and three others had taken tests but had never requested or received an evaluation of the results.

One woman said, when asked about aptitude tests, that she felt the tests were used to "pigeonhole" participants.

8. Decisions for placement. Seven women interviewed said no decision had been made concerning their placement. Of the five for which decisions had been made, three said the decision was made with the counselor and two felt the decision was made based on what was available at the time.

Of those placed, one felt that she had not been given adequate information about her placement. She described her experience as

being given a tour of the shop and told what her responsibilities were by the foreman, then given different information by the union stewart and another individual she did not identify.

F. NEEDS OF WOMEN IN THE AREA

The women interviewed that were enrolled in the BJW program were different from women interviewed at other sites in that they were all interested in non-traditional occupations.

These women identified needs that most women have in securing employment in addition to harrassemnt and lack of acceptance on the job.

The women interviewed that had only attended orientation were interested in traditional jobs and the needs they identified were more in line with needs identified by women at the other sites visited.

1. Job history. Of the twelve women interviewed, five considered their present (or last, for one woman who had been laid off) positions their best. The other seven who preferred something other than their present jobs represented varied occupations and interests. Some of these were teacher, correspondent, maid, secretary and waitress. The women who gave these occupations as ideal said they found them stimulating and rewarding.

2. Present job problems. The next question asked what problems there were with the present jobs of the participants. Inadequate salary was the most frequent problem cited by women concerning their present or last job.

Four found their present jobs unsatisfying and below their abilities. "Boring" and "monotous" were terms used to describe their

work.

One woman, the only woman on her shift, said there was "lots of harrassment." Three others indicated that this was a problem at their work sites, too.

Benefits such as sick leave and medical insurance were felt to be inadequate by two persons interviewed. A woman spoke of her work site as being "non-union" and "without a future and security."

The description of another was that her supervisor was "on the make" and rejection of his advances resulted in her being singled out for excessive criticism, while the other employees were allowed greater freedom. This was occurring in a plant where the ratio of employees was three females to sixty males.

Transportation was cited by one woman as being a problem. She said she has to take two buses for 45 minutes or hitchhike to the work site.

Work hours, particularly shifts, were said to create some problems with spouses when their work shifts did not coincide, according to two women. Others said they had no social life because they were expected to work overtime and on weekends.

3. Ideal jobs. When asked about ideal jobs and salaries the range was from $365/month for a waitress position to $20,000/year as a biochemist. "Very little, but more than welfare payments," was one stated salary goal. None of the women indicated that they would rather not work.

Five participants said they would prefer to eventually own small businesses. Woodworking, livery stables, and boutiques were mentioned as possibilities for future businesses.

4. How to get the ideal job. In response to the question about what they would need to get the ideal position, five women said they needed counseling and vocational/skill training. Four said they would need life and medical insurance, paid vacations, and sick leave.

Four other women felt the need for more income and financial planning.

Child care and creative work situations, such as flexitime, were mentioned twice. Only two of the women interviewed had children and both expressed the need for child care.

5. Other needs not covered. When asked about other needs, one participant asked, "How do you reclaim a life time spent on jobs which underutilize one's abilities?" This question was asked by an older worker who feels that BJW is for "younger women" who can lift heavy objects and take time for training.

The other needs identified by women were inadequate housing and financial support.

The age limitations for apprenticeship programs is a very real concern of women seeking help by BJW for such placement. The legality of these age requirements is being investigated by one BJW applicant.

6. Needs of other women in the area. The women interviewed saw many needs of other women as well as their own. When asked what these needs were these specific concerns were given:

1. problem of being only woman working with "pig" men; need for critical mass
2. moral support when going before the union boards
3. another agency like BJW with emphasis on white collar jobs

4. a meeting place, such as a coffee house, for women to share concerns

5. self-motivation; "a lot of women are just too lazy"

6. ESL for some women so they can be upgraded in positions

7. retirement planning and added skills to supplement fixed incomes

8. work hours that allow a person to attend to family responsibilities

9. help with finding time to job hunt if employed in undesirable jobs and not able to afford to lose income while seeking other employment.

G. SUPPORTIVE SERVICES

BJW maintains and distributes a listing of resources "in an effort to help the women served by BJW learn what resources are available to them in the community." Community Resources is a supplement to the free monthly newsletter and contains a diversified, though admittedly, incomplete, list of community services. BJW acknowledges the needs of their clients and their difficulty in securing adequate information that may lead to solutions. The staff encourages clients, potential and present, to discuss any problems they have that are barriers to employment.

1. Child Care: Two staff persons said there was child care available at their location for participants who come for orientation or have appointments for job interviews. Two other staff members said that money is provided in the budget for client needs, if they have just begun work, until they receive their first paycheck. Another staff person said, "the problem with day care is that it is day care," adding that, "a lot of blue collar work is graveyard shift." The BJW staff also refers clients to community resources listings.

2. Transportation: Four of the staff interviewed said there were bus tickets for orientation, interviewing and testing. In addition. there are funds for gas and parking fees.

3. Medical/Dental Needs: One staff person said there were no funds for this service and three indicated that referrals were made when women had either of these needs. According to another staff member BJW is "very picky" about the physical condition of the women chosen "because of the nature of the work involved."

4. Mental Health/Personal Counseling: Two staff said referrals are made to other agencies and another said she had never done referrals for these needs. According to one staff person these needs are identified during counseling and "everyone does some counseling."

"Clients come out with some really incredible things," said one staff person, adding that they "just need someone to talk to and that's all I feel qualified to do, to listen."

5. Legal Needs: Of the three staff persons responding to the issue of legal needs of women , two said that legal needs usually have to do with "stuff that is going on on their jobs." A senior staff member said an effort is made to find out what's involved. She said in some cases the BJW staff can handle the problem. If this isn't possible the women are referred to another agency.

The Community Services in Metropolitian Denver and the Women's Resource Book are two additional directories listing referral information of services available in the Denver Metro area. The first can be obtained through Denver United Way and the second is available at the Denver Woman to Woman Bookstore. The BJW listings in Community Resources are a representative sample of those given in the other two reference books.

H. SUMMARY

The focus of the program is necessarily narrow to serve a particular group of women. Because of this some women who are unsure of their abilities and choices are not served by the program.

The committment of the staff and their clear focus on program goals give the program a progressive, dynamic thrust.

This program has had a significant impact on opening employment opportunities in the non-traditional occupations for women.

Two innovative features of the program are a slide presentation depicting the realities and difficulties women face in non-traditional jobs, and a work station for assessment of physical strength and ability.

The existence and success of this program also makes a statement for categorical programs.

RECOMMENDATIONS

IV. RECOMMENDATIONS FOR SERVING WOMEN IN CETA PROGRAMS

These recommendations and their discussion are intended to be examples of the types of issues and program options that CETA staff and planners should consider in order to more effectively provide services to women. It is not an exhaustive statement on any item raised. Individual programs may feel that some of the ideas could apply to their operations while others do not; this is to be expected. Some suggestions may seem idealistic, impractical, or politically improbable in particular prime sponsor areas, but this does not diminish their worthiness as possible program options in these and other areas.

The point of this final section is to begin what should be a creative process of self-evaluation for CETA programs. The recommendations will hopefully stimulate readers to consider new ideas and program approaches for their own programs' services to women. If the section fosters discussion of program improvement and innovation in order to more effectively serve women, it will have accomplished its purpose in facilitating positive change.

A. POLITICAL OFFICIALS

Recommendations for local political officials and the Governor:

1. Know the CETA law.
2. Know what is going on in the local program.
3. Select a demographically representative staff for CETA.
4. Define responsibilities and communications carefully with hired CETA staff.
5. Give creative leadership to the CETA program.
6. Facilitate interagency coordination within the CETA program and monitor it.
7. Appoint planning council members carefully and include known women's advocates.
8. Strengthen the role of the planning council.

Additional recommendations for the Governor:

1. Encourage new prime sponsors to form.
2. Facilitate interagency and interdepartmental coordination, especially in supportive service areas.
3. Become involved in CETA BOS.

The whole concept of CETA relies on political officials of prime sponsorships being integrally involved in the application for and administration of CETA funds for their areas. In order for such officials to be effective in this capacity, several recommendations for effective involvement follow.

1. Know the CETA law. Political officials must understand the CETA law and what it can do for their areas. Local staff and regional DOL can provide such information. In addition, local political officials can join with other prime sponsor officials to take part in lobbying efforts on behalf of CETA to modify it as needed. National associations such as the National Association of County Officials (NACO) and other groups have CETA program sections at their meetings. Political officials should find the appropriate group and involve themselves in order to assure that CETA remains or becomes a law that is helpful to its areas and its female population.

2. Know what is going on in the local program. Locally, political officials must require regular information from CETA staff on the effectiveness of the program. Political officials can also obtain

information themselves through personal visits with staff and clients at program locations as well as to consult with local employers involved in CETA. Attending planning council meetings and remaining current on the present comprehensive plan as well as the proposed plan for the next year are others ways of staying informed. Political officials must become aware of women as a client group and see that services respond to women's needs.

3. Select a demographically representative staff for CETA. To do the actual work of operating a program, political officials must delegate responsibilities to hired CETA staff, who should be carefully selected to have the necessary administrative and fiscal skills to fulfill DOL agency requirements. Staff must also be selected for their human relations and community involvement knowledge in order that they can effectively work with the client population. Most important, the staff must reflect the demographic composition of the community to be served which is at least 50% female. This will require a strongly written and enforced affirmative action plan to assure the appropriate mix of staff.

Staff must have human relationship experience in both agency and community organizational settings in order to understand through their own experience the clients that they will serve and the kinds of agency outreach and intercoordination of effort required to operate a program which is meaningful to the community. It is not enough to hire college degreed staff with good intentions if they lack community contacts and relevant personal experience since these latter traits are more likely to contribute to their effectiveness and rapport with the community than any particular educational background.

4. Define responsibilities and communication carefully with hired CETA staff. After hiring such a staff, political officials and senior staff must reach a very clear understanding of the division of responsibilities and the kinds of structured and informal communication each desires from the other. The research staff found examples of staff who were resentful of their political officials because there seemed to be perpetual uncertainty about when the officials might decide to intervene into the operation of the program. Of particular concern was unplanned intervention which commanded resources planned for some other use, or the political officials desiring preferential treatment for an agency or individual of their choice. Such staff felt that the political officials should have given their input at the appropriate planning stage of the program. While the political officials are the titular heads of the program, they are not the operational heads. After hiring competent staff, they must then allow these individuals a high level of autonomy in carrying out the program.

Staff can contribute to better communication with their political officials by providing them with regular information on the program and its operation, structuring this educational information into the ongoing relationship with the political officials. The political officials, in return, should provide feedback when desired by the staff and contribute in any way possible to the smooth accomplishment of program goals. The ideal political official-staff relationship would be somewhere between the extremes of domination on the one hand and neglect, however benign, on the other. Following the mutually agreed upon division of responsibility and communication becomes the obligation of both parties in the relationship and is critical for providing needed services to women and other client groups.

5. Give creative leadership to the CETA program. Political officials can do much to give creative ideas and leadership to the area's use of its CETA funds. Their ideas, channeled through the staff and planning council, carry additional weight because of their political office, although these ideas should be suggestive rather than directive. Political officials can offer new kinds of projects and services they see as needed in the area for WE and PSE projects, for instance, rather than guiding the CETA program toward a "pedestrian" use of such components to carry out existing municipal services. Political officials must contribute new ideas for improved services to women and support creative projects in the community which carry out this goal. (See discussion later in this chapter on WE and PSE components.)

6. Facilitate interagency coordination within the CETA program and monitor it. Such coordination will assure that CETA is cooperating and exchanging with other human service organizations in the community. Political officials can assist in identifying which organizations in the community might contractually be associated with CETA, whether through financial or non-financial agreements, in order to better serve women clients' needs. Assuring fair and open competitive bidding for any funds spent outside of the CETA agency would follow with this commitment. Because CETA program operators are necessarily more parochial in focusing on their own particular program, political officials need to assist CETA and other programs to develop long-range perspectives and interconnection with each other and the community rather than exist in a state of agency isolation. Political officials must assure that interconnection occurs with women's centers, continuing education programs for women, and other women's groups as a part of this plan.

7. Appoint planning council members carefully and include known women's advocates. Critical to the quality of the CETA program in each prime sponsorship is the nature and impact of the planning council. Since planning council members are appointed by the political officials, their selection needs to be a careful and deliberate process rather than an arbitrary appointment of individuals known to either the political officials or to the program staff. Since the councils are, by law, to be made up of representatives of various community interest groups (see discussion of CETA law in Chapter I) including clients, it is quite reasonable that these interest groups should be a part of the council member selection process. To assure that women's interests are well represented, political officials must consult with local women's groups for nominees of interested and qualified women, rather than assigning a woman to represent women's interests when she herself may have no community organizational experience or constituency. Known women's advocates must be selected for council membership.

Other interest groups, such as business or agriculture, might become more involved in the planning councils if they felt involved in the selection of representatives for their interests. This can be done through such organizations as the Chamber of Commerce. Working with such organizations would have the added benefits of developing positive public relations for the program and assisting in staff job development efforts. In addition, a special employer's advisory council might be formed with the community, such as the Industrial Advisory Board of OIC, to supplement the planning council's work. Some experimentation with media advertisement soliciting nominations of individuals for special boards and the main planning council would be useful.

Such a process would broaden community input which is the whole purpose of the council's function under CETA.

8. Strengthen the role of the planning council. Once a representative group of committed community members is appointed, including those who are or have been clients themselves (rather than agency staff designated as speaking for clients), the political officials can do a great deal to insure that the council shares in the decision making for the program along with the program staff. The weakness of many planning councils is that they become "rubber stamps" for the staff and/or political officials' plans, rather than serving as a third and functional party in the decision making process. Often, this becomes the pattern because the councils are only provided with superficial information on the program and are not in a position to realize that they have only token involvement. Or, strong client advocates are not appointed or reappointed, leaving a rather passive group of people functioning as the council. A representative and well informed council which is allowed to share in the decision making is a giant step toward including women's interests in the CETA program.

Additional responsibilities under CETA are given to the Governor and other state officials:

1. Encourage new prime sponsorships to form. The state must assure that all geographical areas are included for receipt of CETA services, including the encouragement of eligible applicant city and county jurisdictions to be their own prime sponsors. The benefits of local control of CETA funds need to be stressed to these jurisdictions. Although an eligible area is not obligated to assume a prime sponsor role, and such cities as Lakewood and Aurora have chosen not to become their

own prime sponsors, the state must still assure that services are provided to those areas. In addition, the Governor and other state officials must monitor such programs carefully to assure that they provide services to meet women's needs.

2. Facilitate interagency and interdepartmental coordination especially in supportive service areas. The state must also assure that there is cooperation and participation of all state agencies providing services which in any way would affect CETA and that this cooperation and participation occurs at every prime sponsor level. In order to accomplish this, the law requires that the state set forth a plan for the development and sharing of resources and facilities, including an assurance that the state ES is a part of the planned sharing. The law also requires that the state provide for an exchange of information among state and local governmental units' programs to prevent duplication, conflict, and overlap between areas and their services. In the case of women, such a coordination would assure that women are targeted for service in each area and that services to meet women's needs (including supportive services) are provided in an equitable manner.

In Colorado, this strong leadership role for state officials is largely unrealized and is a coordination effort which must be performed. Such coordination would benefit the state by providing for a more efficient use of CETA funds and would benefit local programs who want state level leadership. Women would benefit from access to a wider range of services if coordination were present. In particular, the Governor and state staff must coordinate the supportive services required by women clients in such areas as child care, transportation, mental health, medical and legal services, etc. at the state level so

that this may more easily be a reality at the local level. This may require written agreements, for instance, between the Department of Labor and Employment and the Department of Social Services to provide child care which might be funded through the Title XX (Social Security Act) funds allocated to each county. The majority of CETA Title I eligible women, whether receiving welfare benefits or not through Social Services, are income eligible for free or subsidized child care under the Social Security Act. Generally, CETA women clients are not receiving these child care services, or the arrangements are left up to local CETA programs and their county Departments of Social Services. Such agreements at the state level would allow local programs to more easily meet the child care needs of clients and direct CETA dollars into other training and employment services. (See additional discussion in supportive services section of this chapter.)

In addition to supportive services agreements such as that described above for child care, the Governor must see that necessary economic and employment data from the Deparments of Labor and Employment and Social Services are available to local prime sponsors for their use in planning. Further, state coordination between such departments will facilitate such sharing at the local levels.

3. Become involved in CETA BOS. The Governor has mainly delegated whatever CETA functions he has to a Special Grants staff, the State Employment and Training Services Council (SETSC), and various senior staff of the Department of Labor and Employment. While this delegation is perhaps unavoidable, the Governor needs to keep better informed through more regular contact with prime sponsors and other BOS political officials. One way to do this would be to attend at

least occasionally, SETSC meetings along with prime sponsors and other state leaders. Planning councils in the BOS, which are appointed by the Governor, would benefit from feeling a greater sense of the Governor's leadership and interest in their work since he is now perceived as uninvolved and poorly informed about the BOS CETA program.

In addition, the same recommendations for local officials also apply to the Governor in his role as titular head of BOS CETA.

B. PLANNING COUNCILS

Recommendations for planning councils:

1. Be knowledgeable about CETA.
2. Be knowledgeable about the local CETA program.
3. Work toward representative council membership.
4. Be a functional planning group.
5. Be involved with women and the community.
6. Include women as target groups for CETA services.
7. Require interagency coordination from the CETA program.
8. Publicize the comprehensive plan and the CETA program.
9. Evaluate the council's impact.
10. Have impact beyond the local area.

The council should work with the political officials and the staff in a three-way shared decision making capacity. In order to be effectively involved, however, various preconditions are necessary:

1. Be knowledgeable about CETA. Councils need to be informed of the CETA law, its regulations, and its instructions, and general national discussions occurring around the CETA law. To acquire this CETA background, the council should request whatever orientation they feel they need, whether in written or oral form, from the staff and/or political officials, as well as request direct assistance and orientation from the federally authorized representative (FAR) assigned to their prime sponsor area. Region VIII DOL's Regional Training Center (RTC) offers numerous courses that council members can attend along with program staff. More specific DOL technical assistance to a particular local area is also available on request. A regular system to keep informed is mandatory because of the volume of CETA

regulations and instructions, which both alter federal expectations of local programs as well as the range of possibilities for local program use in serving women and other client groups.

2. Be knowledgeable about the local CETA program. In order to develop knowledge of the actual operation of the local program, council members must receive part of their information through staff reports, but members must seek out their own sources of information on the program. This may include spontaneous visits to program and training sites, conversations with staff and clients outside of council meetings, talking with local employers involved with the CETA program and other ways to learn about the program and how it affects women.

The council must have an understanding of the reporting documents submitted to DOL and their contents. Also, the council must be kept current by staff of any program directives from DOL and how these are to affect the program. Before a council, then, can hope to improve services to women or any other group, it must know what is going on in its local program.

3. Work toward representative council membership. Although planning councils usually do not have the authority to appoint their own members, they must work with the political officials to assure that needed representation from the community interest groups designated in the law are actually on the council, including present or former clients. (see Chapter I discussion of CETA law and previous discussion of political officials and planning councils). The council can facilitate an open process whereby community groups or individuals can bring nominations for council membership to the attention of the political officials and then monitor that the officials do appoint a representative group which is proportionately female.

4. Be a functional planning group. If there are council members who are not committed to the work of CETA and who by poor attendance or other indication or marginal involvement keep the group from functioning effectively, the council should discipline itself and seek the removal of these individuals from membership. Actual bylaws or other organizational documents are advisable in order to structure the efforts of the group and to insure that the work load is shared fairly among the members. The bylaws may specify specific attendance and work obligations expected of members to insure that it is a working council which meets regularly and accomplishes its goals. The council needs to assume more responsibility for its membership and its governance rather than totally relying on directions from the outside by politicians or staff, impeding effective functioning.

In order to encourage the full involvement of all members, councils should meet in the evenings or on weekends if this is the most convenient time for the highest number of members. Day meetings can only be attended by those whose employers will allow them release time, and this is not all potential members. Travel and per diem expenses should be provided especially to insure the participation of low-income members.

5. Be involved with women and the community. The planning council must view its work as occurring at three levels. First, it must work with the political officials to understand their views and to give its own. Second, it must work with staff to obtain program information and staff recommendations for program planning as well as suggest program directions. The third is perhaps the most important level of council work. The council must work with the community since council members are accountable to their community constituencies and

need to be in a regular state of communication with them. It is only through community feedback and evaluation that council members can work with staff and political officials as a voice of the community.

Community input may be solicited in a variety of ways. It may occur through council members' participation in community based organizations and agencies where community members can share their ideas informally. In a more formal manner, following the model of Congressional hearings and committee proceedings, members of the community may be individually invited to give "scheduled testimony" in written or oral form to the council. This encourages people to actually come to any community input meetings that may be held and feel that their ideas are being heard and potentially acted upon. Staff and political officials may need the same kind of personalized invitation in order to assure their participation.

The council can also assist in developing and publicizing a specific grievance procedure for clients or staff who wish to formally register their concerns beyond such open meetings. Such procedures should explain an appeals process through the local, state, and federal structure for those individuals who wish to pursue their cases to these levels.

As a regular advisory group, the council may want to form special task forces with the community. A women's advisory task force, a part of some non-Colorado programs, would be such a group which would give specialized community input on women's needs. Special task forces of employers, especially those who provide CETA subsidized jobs within the CETA program, or other interest group would prove useful to the planning council's work.

6. Include women as target groups for CETA services. Since under the law, the CETA professional and clerical staff are to be made available for the use of the council, the council should make use of them to locate necessary information needed for planning. Specific directives can be given to the staff to develop the desired data. Staff should be directed to investigate such items as the unemployment rate, the incidence of poverty, educational attainment, supportive service needs, etc. for the various different sexual, ethnic, racial, and other groups in the population. These data then become the basis for a rational choice of target groups based on degrees of need. Several prime sponsors, such as Denver, are developing intricate matrixes of need at the present time to provide data for their councils on which groups in the community are most in need of services and what kinds of services each of these groups needs to have provided. In order for CETA funds to be most effectively used to provide services that are not available elsewhere in the community, a clear understanding of client needs as well as available other services is needed. The comprehensive plan, which is produced by the combined efforts of the council, political officials, and program staff, should not be based on guesses or personal priorities of what the community needs, but on as much hard data as possible on what those needs and wants actually are. Where employment and economic data, for instance, are inadequate from state and federal sources, councils should join staff efforts to demand better planning data, especially reliable and current data needed from the state's Department of Labor and Employment and the federal and regional offices of DOL and the Bureau of Labor Statistics.

In order to use such information, the council must direct

the staff to make as much of this information available ahead of meetings as possible. Council members need advance time to study and plan from this data before the meetings.

7. Require interagency coordination from the CETA program. For local data in such areas as needs assessment, councils can direct staff to jointly carry out such studies with other community organizations. CETA resources, in the form of staff time and/or the creation of PSE positions, can be provided to accomplish such an effort, if needed, in order to launch an ongoing process of having adequate information on community needs. If data are available from other agencies, councils need to see that such data are a part of the CETA planning process.

Councils should require staff to investigate thoroughly the services of all related community organizations and agencies which might relate to the CETA program and client supportive service needs. In the case of services to women, all such organizations and agencies which serve women, such as women's resource centers, continuing education programs for women, etc. should be explored. In addition, all local agencies providing information and services in child care, transportation, medical and legal services, mental health, and other supportive service need areas of women must be specifically incorporated into the service delivery plan.

8. Publicize the comprehensive plan and the CETA program. Just as the council solicited community input during planning, the final plan should be available to all related organizations and interested individuals. It should be publicized through available media and service directories in order to give it high visibility to women as an effort to reach clients most in need of service. The council

can assist in urging and accomplishing this visibility by circulating copies of the plan themselves, discussing it with community groups, and generally assisting in informing the women in the community of its existence.

9. Evaluate the council's impact. Although in a final legal sense, planning councils are only advisory to the political officials and program staff, there is no reason why this needs to result in passive, inactive councils. If sufficient community based support and representation are present from women and other client groups, the councils have a constituency and can act as a powerful element in the CETA program in all of its aspects. A more assertive and informed council becomes the third interest and decision making party along with staff and political officials in the CETA program. Such an expanded role is vital to the community advocate and representation role which councils must serve. Their potential is underutilized in most CETA programs, perhaps out of staff or political official concern that the program will be found to be deficient or in need of radical change by an informed council.

As a part of the regular DOL review of local programs, councils should contribute their feedback to DOL on the program and the council's role in it. Rather than the FAR evaluating the council, the FAR should assist the council in evaluating itself.

An effective program is not risked by sharing its successes and failures with a council and its community members but rather is strengthened by council and community involvement. Councils are the linking element to the community being served and a location for women's input into the CETA system. The council must be evaluated in terms of whether it is living up to this potential.

10. Have impact beyond the local level. If council members are well informed about CETA as a law and their own local programs, and communicate and share decision making regularly with political officials and program staff, they can also take part in other activities that are a part of the larger CETA system. They may wish to initiate information exchanges with other prime sponsor areas or nominate their members or community people to the Governor for membership on state councils such as the State Employment and Training Services Council (SETSC). Since CETA is a relatively new law and President Carter desires economic stimulation for the country, continuing Congressional debate will likely occur regarding whether CETA is working, how it can assist any public works projects, and whether any changes are needed. Council members, as informed lay representatives of their communities, need to be a part of this process of providing citizen input to the various levels of government and its bureaucracy which are involved in CETA beyond the local level.

C. PROGRAM DELIVERY

Recommendations for planners of program delivery system:

1. Expand on the totally in-house plan to include contracts with women's community based organizations.
2. Expand on the single major contractor plan to include contracts with women's community based organizations.
3. Work toward a multiple contractor plan with contracts to women's community based organizations.
4. Consider categorically funded programs for women as a part of or along side of the regular CETA program.

There is no one best way to use CETA funds at the prime sponsor level or to design services that will best serve women in that area. Various approaches are possible. However, it is incumbent on local programs to define as many alternative approaches to deliver CETA services as possible. This requires that political officials, program staff, and planning councils know their community resources and organizations quite thoroughly. Under the CETA law, there is freedom

for individual programs to identify their own particular administrative model for conducting and delivering CETA services. There are, however, some directives in the law specifying that community based organizations capable of providing such services must be considered for funding. Also, the law states that an effort must be made to utilize the services, whether free or for reimbursement, of federal, state, and local agencies in designing the particular model of service delivery for each prime sponsor.

Four basic models of CETA service delivery, all present in the state, merit analysis as possible approaches. Pros and cons of their potential for quality service to women will be highlighted as a part of the following recommendations:

1. Expand on the totally in-house plan to include contracts with women's community based organizations. The "in-house" plan is one where CETA funds are received by the political officials who then hire a staff to carry out the program as a newly created CETA agency. Adams, Weld, and Pueblo Counties operate basically under such a system. There are no major contracts with community or other organizations for delivery of services because all CETA services are delivered by the one centralized unit. This form allows for a high level of control over program and staff activity because all services are provided literally under one roof. Under such a system, there is a greater possibility for uniformity of services to clients, rather than risking the situation of local contractor agencies each providing qualitatively different kinds of services to clients. Because there is one set of administrative staff for the whole program, rather than additional administrative staff at each contractor's locations, administrative costs can be held to a minimum and greater amounts of funds

can potentially be made available for direct services to clients. Program changes may be more easily made in such a program because of staff accessibility for communication. It is a model which is a viable one for a small prime sponsor where local people with sufficient expertise for staffing are present and the population is numerically small enough to be served at one location.

The in-house plan has some drawbacks, however, especially in providing specialized services to women. Because there are no contracts with community based organizations, such as those focused on women, there is a risk that the CETA program will become seriously isolated from community organizations and their members. Further, many such community based organizations could be more effective and credible deliverers of service for women and other particular population groups and might very well have adequate or superior experience in working with economically disadvantaged people in general. This is true in some areas of the BOS where the ES is the only deliverer of CETA services. In this case, there is every danger that existing negative attitudes toward and experiences with the ES can cause damage to a small CETA program operating within it. Women's organizations and other groups could become part of the CETA system and take some of the "burden" off the ES to attempt to serve everyone in one mode of service.

Where in-house programs exist, some staff explain the situation as resulting from an absence of local community based organizations. If this is the case, and this assumption needs to be checked out carefully, CETA programs could use PSE or WE funding or other methods to develop the needed expertise in other agencies in order to allow

themselves additional program delivery options in the future. For instance, women's resource centers and related organizations providing counseling and other services to women could add valuable services to the community through additional PSE or WE staff. At the same time, these organizations would be acquiring experience needed to competitively bid for a contract in the following year's CETA delivery system.

In populous areas, an in-house program runs the risk of becoming overly large and bureaucratic, to the point where clients do not feel personalized or individually served. Staff in such large CETA agencies may also feel aliented toward the program and fail to deliver their best service to their clients. With a monopoly on CETA services in the area, friendly and constructive competition between CETA funded agencies, which can result in improved services from each, is not present. In-house programs, then, may become complacent in their autonomy. Women, and especially those without "agency savvy," may feel intimidated and uncomfortable in such a setting and may not seek or return for service.

A variation on this in-house plan is used in Jefferson, Arapahoe, and Boulder Counties. In these counties, the program is mainly handled in-house but there are small contracts with local organizations for a portion of the CETA services. In each of these three counties, one such contract is with a women's organization or project in the community. However, since the contractors share only a minor amount of the funds and the decision making, the pros and cons discussed for in-house plans still apply although such programs are in transition toward a multiple contractor plan. Such small contracts, then, are significant because these programs are more likely to be providing better

services to women both through these outside contracts and internally since they have recognized these services as important to be provided within the CETA system.

2. Expand on the single major contractor plan to include contracts with women's community based organizations. A second program model is that of a single major contractor for delivery of CETA services with the prime sponsor reserving only a small portion of the CETA funds to provide for an administrative staff. Larimer County is such an example in this state and in this instance, the major contract is with the ES. The advantages of such a system stem mainly from its simplicity, since the contracted organization is expected to carry the major responsibility for the CETA program and at a separate location from that of the administrative staff. For newly formed prime sponsors, the plan has its advantages since the major contract can be awarded to an experienced agency which may, in effect, help to teach the inexperienced prime sponsor what a training and employment program could include. If several agencies bid for funds, stiff performance criteria can be written into the contract with the single agency funded. The organization must either perform according to the criteria or face being financially cut off from the program's funding during the following year. There is some capacity for uniformity of services to clients since the single agency presumably has the capability of providing uniform services to its clients already.

However, this setting, like the in-house setting, may not be a comfortable one for many women desiring CETA services. And for groups who historically have not been well served by the single contractor agency, such as women's experiences with the ES, the single contractor

arrangement poses special problems.

Other drawbacks are present in this model. Sometimes this arrangement is formed because there are no recognized organizations in the area prepared to deliver CETA services. By default, one agency gets the contract. Because the prime sponsor may not wish to form its own in-house program, contracting out in some form becomes the desired management of a CETA program.

The staff in the single contractor organization face special problems of potentially being given two sets of directions for work from both their agency administrators and from the CETA administrative staff. Problems of split loyalties may result. If the contractor agency is not a comfortable place for all members of the population, such as with the ES, the program may suffer because of its location in an unpopular local organization.

The single contractor model, then, sometimes occurs out of a sense of necessity or expediency to get a CETA program begun, but as a long-term arrangement, would seem to have more problems than possibilities. With some effort to locate or develop other community organizations, as in the expansion beyond the in-house plan, a multiple contractor arrangement may prove more manageable and effective if contracts include women's community based organizations.

3. Work toward a multiple contractor plan with contracts to women's community based organizations. A third administrative model is that of a multiple contractor pattern where more than one community or state organization are funded for delivery of some portion of the CETA services. The two most urban prime sponsors in the state, Denver and Colorado Springs/El Paso County, are examples of this plan

as is the least urbanized prime sponsor, the Balance-of-State.

The advantages of such an approach are that various organizations and methods may be included in the delivery system, providing a wider range of client options. When the multiple contractor pattern includes community based organizations, target populations served by those organizations may more readily seek and receive CETA services in a setting most comfortable to them. Because of the presence of various organizations in the CETA system, clients can enter from various points which may mean that a wider and more representative population is reached. This wider population, if also served by a demographically diverse staff in the various contracting agencies, may be better served by the availability of role model staff who hopefully can relate more meaningfully to the clients. Women and other target populations can benefit for all of these reasons in such systems.

A multiple contractor system, if skillfully planned and administered, can result not only in a wider variety of services than in other models, but in agencies who compete yearly for refunding and must demonstrate their continuing state of effectiveness. Stiff performance criteria for service to clients can be placed in such contracts with these agencies which can result in a high quality, well monitored program. A friendly interagency competition can even result, which can be positive if it results in each trying to outperform the other in such services as better placements for clients. In addition, both public and non-profit private as well as private for-profit organizations can be utilized which can result in the inclusion of a variety of women's organizations, resource centers, continuing education for women programs, state and local commissions

on the status of women, etc. With such organizational variety, various internal "experiments" can be developed which try different combinations of services and modes of delivery which should result in highly favorable outcomes from the client's point of view.

If well administered, such a multiple contractor system can result in highly coordinated linkages of services between these and other community organizations. Women's supportive service needs, for instance, can be met through financial and non-financial agreements with a whole host of community organizations to provide such services. Some agencies, such as women's resource centers, may be able to provide such services in addition to job training or placement services and some may only be able to provide their own unique supportive service area, all of which could be planned into a coordinated delivery system.

On the other hand, such a multiple contractor system can be an administrative nightmare because of the many different agencies and their differing goals, staffs, and services. With so many different approaches, the major difficulty is keeping informed at the administrative level of what is actually going on in the various contractor organizations. Requests for information for even the most sophisticated management information system (MIS) may seem irrelevant to the particular kinds of programs or services being conducted at any one organization and may actually be inappropriate data to demonstrate the actual job being done. For instance, a contractor's main task may be to do adult basic education, which it may accomplish in a defined number of weeks by bringing its clients from their entry functioning level to GED readiness level. Such an agency may feel that it is inappropriate for them to have to submit job placement data

since they do not feel that such an indicator is relevant to their task within the CETA system. Other agencies, such as women's centers, might specialize in pre-employment job exploration or counseling and would resent being evaluated on other than these particular activities. New modes of data and monitoring would need to be developed for a multiple contractor system which would then be translated into the form required from DOL.

If such a multiple contractor system is not well planned and coordinated, there is every danger that duplication and overlap of effort as well as gaps may be present within the system. Clients in such large systems may not necessarily get the full range of possible service options if each participating organization does not readily refer clients to one another. If the different agencies feel hostile toward one another or simply lack sufficient information to do regular referrals, clients may suffer since they are only offered the limited range of services that their entry-point agency provides or is willing to refer them to. If women enter the system at a woman advocate point, they may experience CETA quite differently from women entering at single mode "person oriented" points who may receive less satisfactory service. Coordinating special women's services contracts with the rest of the program, then, is a major administrative problem in this CETA model.

In order to administer such a multiple contractor system, special attention has to be given to developing ways to integrate the various services into a meaningful system. Different agencies have to be oriented to one another's work to facilitate referrals. This requires finding the appropriate level of centralization needed to keep this integration without so dominating individual contractors

that they have no freedom to add their individual and creative pieces to the whole. The state of over-centralization may result in alienated agencies and agency staff who feel that the central administrators do not understand their views or agency accomplishments. Or, too little centralization and coordination can easily result in a chaotic non-system of isolated mini-programs with poor inter-referral and non-uniform services to all clients, who may feel totally confused about how to obtain the services they need.

For agencies whose whole financing is based on CETA monies, whether through direct contract or through regular use of PSE funds to provide themselves with staff, a particular kind of dependency on the CETA system may result. This dependency makes the CETA decision for awarding contracts difficult since some such organizations may fold if not continued with CETA funds. And, these same agencies lack the freedom to innovate for fear of losing their only funding through CETA. Some balance would seem to be ideal in this situation, where CETA encourages or even requires contractor organizations to have other sources of funds available if CETA funds are reduced or eliminated. CETA programs can and perhaps should do some initial funding of agencies, especially new ones, but some performance criteria concerning locating other sources of supplemental funding by defined points in time would seem to be advisable. The CETA program could assist contractor organizations to locate addditional sources of funding, allowing them to develop other services which might also serve CETA clients (and meet their supportive service needs) as well as allow them some future state of autonomy from CETA control. The CETA system could then truly have a competitive bid and contract award system, freed of the dependencies of such organizations, which

allows the system to modify or continue services as needed to meet the population's needs.

Although achieving a well integrated and administered multiple contractor system is difficult, women stand to gain a great deal in this approach because specialized services can be provided by local community based women's organizations supplemented by the other agencies' efforts in the system.

4. Consider categorically funded programs for women as a part of or along side of the regular CETA program. A fourth option, which has only one known example in Colorado, is to seek national categorical type CETA funding and remain outside of the local prime sponsor system completely. Better Jobs for Women in Denver operates under this model and enjoys a high level of autonomy from the distractions of prime sponsor politics and operations. Such programs are generally funded by the Secretary of Labor as model or demonstration projects, which gives the programs freedom to define their purposes and services in as limited or extensive a form as they desire. As specially funded programs, a high level of experimentation and specialization can be attained. Such programs are equivalent to extensions of the categorical programs more typical of MDTA than CETA, where such programs did not need to promise all services to all people and could be quite selective with both. Direct supervision from regional and federal DOL is different and perhaps more limited than that of a program funded through a prime sponsor. Such categorically funded programs can develop their own system of administration and performance criteria which are relevant to their particular kind of program, rather than following prime sponsor types of administrative models and performance criteria.

Because such special programs are like their MDTA predecessors, they run some of the same risks as MDTA programs. Categorically funded programs can become very isolated from other agencies and programs, both those funded from CETA and from other sources, because there is no local accountability for their services. Prime sponsors have the legal requirement to utilize community based planning councils for input into the program, but categorical programs may not face this expectation. Although CETA funded, they can function quite outside the CETA prime sponsor system, where most of the CETA activity presently occurs. As rare institutions, they have few other programs to relate to for mutual help and are not in the situation of competing with other local programs for local prime sponsorship funding. This omits competition, however friendly or destructive, from the picture and further heightens their isolation. While enjoying autonomy, the struggle to overcome isolation may be an uphill struggle in a prime sponsor dominated CETA system, although coordinating their services with other organizations would be much the same task as that faced by prime sponsors seeking to link themselves with their communities.

Whatever its problems, the categorically funded programs for women can and do experience much success in defining carefully their range of services and effectively delivering these to women clients. It is a very viable model for special program for women and needs to exist outside of the prime sponsor political arena in order to freely design and deliver services to meet women's changing needs. Special programs for such groups as women offenders could be approached in this manner. (See appendix of special programs for women.)

Whatever the administrative model for delivery of CETA services, women will be served best if staff are sensitized and skilled in doing non-sexist and non-racist counseling and training. Specialized

supportive service units and staff, with detailed community referral information and available CETA funds for additional supportive service needs, are also needed. CETA programs can bring in outside funds to do particular women's programs, such as through the Women's Educational Equity Act or the Vocational Education Act, 1976 Amendments, both of which fund special services and programs for women and the abolition of sex typed services. CETA can give administrative leadership in local communities to thoroughly assess local needs of women and to arrange for CETA participation in a community effort to serve these needs.

D. PROGRAM

1. Outreach

Recommendations for program planners and operators:
A. Plan recuitment efforts specific to each designated target group of women. (see Planning Council discussion earlier in chapter.)
B. Don't rely on walk-in client traffic to meet target group goals.

A. Plan recuitment efforts specific to each designated target group of women. After an effective planning system has been followed and an accurate set of data obtained to assess degrees of need among different groups in the community for designation of target groups to be served (see Planning Council discussion earlier in chapter), a plan of recruitment for each of these groups is needed. especially in the case of women. Women are a target group because of their higher unemployed state in the workforce and by other indices of need. To reach women for program involvement, a particular effort must be planned because it cannot be assumed that women as a group will find such programs themselves. Publicity should include information on the full range of services offered, rather than focusing on some traditional option such as clerical upgrade courses. Although women

do not always belong to community organizations, an effort at publicity through women's organizations can be made, especially those such as welfare rights organizations which are disportionately female in membership. Low-income women may not belong to many formal organizations but they may attend neighborhood churches, have some involvement in their children's daycare or school programs, receive some medical services at clinics or Planned Parenthood offices, or attend functions at local community centers, which can serve as recruitment locations. Other locations could include ES and WIN office, Vocational Rehabilitation, YWCA, laundromats, free community newspapers, and women's centers and transition houses for women. Minority women may belong to organizations based in their minority communities which would be additional sources of recruitment. Displaced homemakers and female heads-of-household should be targeted groups within the larger female population because of their multiple needs. Equivalently specialized recruitment efforts are needed to reach these women. Many such women are struggling to complete educational programs at local educational institutions and may also be served through women's resource centers at these institutions, which would be other settings for publicity. Legal service agencies working with separated and divorced women might also be good recruitment sites, and so forth.

B. Don't rely on walk-in traffic to meet target group goals. The typical CETA prime sponsor pattern of allowing walk-in traffic to determine the kinds of women to be served is insufficient to serve the needs of targeted women and a more sophisticated form of outreach is needed. If more demand is generated than the available supply of funds and staff can fulfill, which many prime sponsors cite as the reason why they do not seek higher visibility in their communities,

then an even finer distinction of which kinds of clients can be served needs to be made to assure that those most in need get full services, rather than limiting services in order to serve more people. For instance, heads-of-household women with dependents are likely to have more multiple needs than single women without dependents who are also heads-of-household although this distinction is not always made by programs. Minority women who are heads-of-household, with or without dependents, are likely to be in even a greater state of need than equivalent non-minority women and perhaps should be recruited and served in greater numbers. Again, the form of recruitment should follow the careful designation of target populations based on extensive data from the community, since each target group will likely require its own form of recruitment.

2. Intake and Orientation

Recommendations for program planners and operators:

A. Design intake processes to recognize and enroll the designated target groups on an ongoing basis.
B. Determine supportive service and other need areas in application.
C. Screen application questions for sexist or incomplete items.
D. Conduct private follow-up interviews with applicants following completion of application.
E. Choose intake staff carefully.
F. Tell clients immediately if and how program can assist them.
G. Explain the grievance procedure for those accepted into program.
H. Provide information and referral services to those not accepted into the program.

A. Design intake processes to recognize and enroll the designated target groups on an ongoing basis. Most programs at present seem to handle the intake of clients as an application filling out task for clients, followed by a short interview with a staff technician immediately or some few days later. On the basis of this very brief contact, clients are enrolled or turned away from the

program. Or, an application is sometimes taken without feedback given to the client on whether she or he can enroll into the program. Such feedback is sometimes not given for several days or weeks.

If ongoing outreach has been done to the carefully determined target groups of the population, these should be the clients that the intake process should recognize and enroll in a program designed for continual open-entry and open-exit. In addition to having target groups, some programs have developed point systems and other methods to further refine degrees of need to determine who can be enrolled or declared eligible for service under all Titles, including PSE applicants. If extensive outreach has occurred, there will likely be more people wanting service than can be accepted into the program and the fairest system possible to determine those most in need should be developed at each program.

B. Determine supportive service and other need areas on application. Because income alone is not a complete criteria of need, such items as educational and skill level, work experience history, physical and mental health, and supportive service status (such as numbers of dependents, residential status, transportation access, etc.) are relevant in determining degrees of need. Despite program tendencies to "cream" in selection of clients who meet the income criteria and have few other needs especially in the supportive service area (which works to the disadvantage of women who often have extensive supportive service needs), the spirit of CETA is to serve those most in need and this should be kept in mind when designing the selection process. The intake process should enroll clients proportionate to their numbers designated in the comprehensive plan while being consistent with affirmative action program goals.

C. Screen application questions for sexist or incomplete items. An application, filled out when possible by clients themselves rather than by staff, would seem to be a necessary first step as bureaucratic and impersonal as this often seems from the client's perspective. The application should gather information on a whole range of specific criteria which are to be used to determine selection. Care needs to be taken to assure that each question elicits the desired information. For instance, asking men or women whether they are heads-of-household may be asking them a social sex role rather than an economic question when the latter is usually the information needed. Since many unemployed men are being supported by their wives' incomes, they may still answer that they are the heads-of-household because they view themselves as the chief decision maker whatever their income contribution to the household. Conversely, many women may also define their husbands as heads-of-household for these same social and sex role reasons rather than on the fact that their income may be the only regular income for the household. Asking for employment status and income earned by each family member may gather the needed economic information without the confusion of sex role information being included.

In asking about one's dependents, determing the age and physical/mental health state of each is important information, since such an applicant may need anything from daycare services to youth probation services to special care for infirm elderly relatives living in the home, to name a few such possibilities.

In order to facilitate follow-up efforts and to have an available way to contact the applicant, each person should be asked to list a telephone number where they can be contacted. If the individual has no

home telephone, and many low-income people do not, have a section on the application to list a relative or friend's number where messages can be left. The application should also inform the applicant to inform the program if a telephone is acquired or if an address should change.

D. Conduct a private follow-up interview with clients following the application process. After an applicant has completed whatever written forms are viewed as necessary and appropriate, each should have a follow-up interview by a staff member as soon as possible, preferably at that time. This interview should not occur in a public location, such as is frequently done in CETA programs in an entrance area or public lobby, but in a private location in the program offices. One's particular economic and other needs should be viewed as private and confidential information, which is inappropriately and insensitively handled in the presence of other people.

E. Choose intake staff carefully. Because the process of eliciting such personal information is sometimes difficult and requires a special sensitivity, the individuals who perform this function should be selected for their capacity to be empathetic and non-judgmental in working with women and men applicants. Although it is possible that a technician level person will have these skills, it is more likely that someone with additional educational and experiental background would be needed to perform this very important first official step in the program. Counseling staff could be rotated through this work assignment, assuming that they have the desired capabilities or could be trained to have them. This would also keep counseling staff informed of the range of need in the applicant group and hopefully sharpen their interpersonal skills.

F. Inform clients immediately if and how program can assist them. The intake interviewer should have the authority to tell the

applicant whether s/he is eligible for services or not. If the person is eligible, a brief orientation to the program and its full range of services should be given, although clients recruited through an outreach program publicizing specific services from CETA may already have a basic understanding of the program. Additional group orientations for small groups of applicants once or twice a day would be ideal. Doing the orientations, however, after the determination of eligibility has been made is fairer than doing it before, since applicant expectations for program response may be established which cannot be met if that individual is not eligible for service.

G. Explain grievance procedure to those accepted into the program. Before entering the program, the client should receive written information on the grievance procedure at both the local and DOL levels if problems should arise. Clients could sign for receipt of such information, such as occurs in the Grand Junction CETA program, in order to insure its distribution.

H. Provide information and referral services to those not accepted into the program. Since the intake interview discusses information recorded on the application form, if the applicant is not accepted for service in the program, the staff member should spend some time with each individual doing referral in place of a CETA program orientation. Each of the needs which are identified from the application could be followed with staff providing information about what services are available in the community and whether these are free or for specific fees. This would include the provision of such information as the availability of Basic Educational Opportunity Grants (BEOG) and other scholarships to sponsor individuals for training if this is the applicant's desire. If

the person does not meet the income or target group criteria but has good job skills and mainly desires a job, referral to the ES or other location for job information might be appropriate. The point is that no applicant should be turned away without suggestions of where s/he might go for help. Women especially need this orientation to other community services since many lack this wider network knowledge of their areas.

The intake process, then, is a screening for eligibility and a selection of people already determined to be those most in need of CETA services. With program decisions made in advance on eligible groups and their priority for service, the arbitrariness of the intake staff person "choosing" clients based on poorly defined criteria can be eliminated. For those not selected for program participation, whatever the level of economic or cultural disadvantage, the program should assume some responsibility for adequate referral to organizations which can serve each individual. To serve both enrolled and non-enrolled applicants, staff at this level must have a thorough knowledge of community organizations and must be able to provide these informational referral services to all applicants.

3. Assessment

Recommendations for program planners and operators:

A. Require assessment of all clients and pay them for their participation.
B. Use assessment information in client EDPs.
C. Incorporate a cluster of reliable assessment tests or experiences into the assessment.
D. View assessment as a good use of CETA funds.
E. Encourage women to learn from the assessment experience.
F. Select non-sexist and non-racist tests and experiences and interpret them in an open-ended manner.

A. Require assessment of all clients and pay them for their participation. After clients have been selected through the intake process

and have received some orientation on the program, assessment should be a mandatory next step in the program for all clients, including PSE applicants. (See later discussion of PSEs as following the same eligibility requirements as other Titles' applicants.) At this point, the person is a client and program participant and should be provided allowances and supportive services from CETA during this and subsequent steps in her/his program involvement. Stipends for participation indicate to clients that the program views assessment as valuable and necessary while the clients benefit from having some income in order to survive.

B. Use assessment information in client EDPs. Assessment is not as simple as a counselor talking briefly with a client about career objectives and then arranging for training or placement into a job. Rather, it is a step in CETA programs which is often the critical one in that it provides new information on the client for both the client and the program to use in employability development planning (EDP). Even for clients with some job experience and some training, the assumption that the client had a full range of options at the time of this training or work should not be made nor should it be assumed that the client necessarily found such training or work satisfactory. In the case of women, many have worked in the traditionally female menial and low-paying jobs out of necessity rather than choice. Some of these women may have accepted such jobs or training believing that it was all that they were capable of doing at the time. Assessment data, then, are a part of breaking down client and staff assumptions about what is possible and are especially important to assist women in broadening their range of thinking beyond the traditional job areas which women perform.

C. Incorporate a cluster or reliable assessment tests or

experiences into the assessment. Effective assessment provides the client with specific information about aptitudes, interests, potential for different kinds of jobs, and academic functional levels in math and reading. While there are various commercially prepared tests, such as the Kuder Preference Record, the Minnesota Importance Questionnaire, and the General Aptitude Test Battery (GATB), none is a total answer to this need for data, but some combination of these might be a beginning. Work sample experiences are available from such companies as Singer, which establish a simulated work setting in various skill areas for clients to experience. Goodwill Industries has a three day extensive assessment service which does vocational aptitude assessment as well as determining functional educational levels, among other data. Better Jobs for Women has a work sample room of their own creation which assesses physical skills as well as other aptitudes for women considering non-traditional employment. Whatever the chosen cluster of tests or experiences, the purpose should be to provide clients with usable data which can assist the counselor in working with the client to form career goals and a plan for employability. If CETA staff do not have the expertise to conduct and interpret such results, contracting this service to outside organizations could be considered. Whether contracted or not, counselors should be trained in using the data to work with clients, especially to encourage women to become aware of new information about themselves.

D. View assessment as a good investment of CETA funds. Better assessment, although often a costly step in terms of program funds and client time, should be well worth the investment. Ideally, the data should assist in enrolling clients in training programs which they can and want to do, as well as eventually resulting in job placements that

have every likelihood of being long-term, economically and personally for the client. It can prevent clients from entering training that is inappropriate, such as was experienced by one Asian woman interviewed during the research. The woman spoke English fairly well but could not read or write in English. She was placed in a secretarial program and could not do the required work, resulting in both a personal and program waste of time and funds. She had received no assessment of any kind prior to enrollment in the secretarial course.

E. Encourage women to learn from the assessment experience. Women, such as displaced homemakers, are in particular need of quality assessment experiences since they often feel quite unfocused in considering employment possibilities. Many of these women have a variety of skills acquired over the years in raising children and caring for a home, but they may have no clear sense of how any of these skills might influence their aptitudes and career choices. Many other women have only worked in traditional women's jobs and lack information on other aptitudes which they may have. Counselors are often equally at a loss to help such women if additional information on abilities are not incorporated into the program assessment experience.

F. Select non-sexist and non-racist tests and experiences, interpreting them in an open-ended manner. In selecting what combination of tests or experiences to use, great care must be taken to select tests with known reliability for use with other than middle class Caucasian males in order for them to be useful for women. Many existing tests are sex- or race-biased, making their scores for women and minorities an inaccurate reporting of interests and aptitudes. Therefore, interpretation of the tests must be made in a non-racist and non-sexist way such that manual dexterity does not translate as

machine operator for men and typist for women. Tests should provide open-ended data which, with unbiased interpretation, can do much to encourage career thinking in more than just the traditional career areas for one's own sex. Information on tests without sex or race basis is available from the Career Education Program of the National Institute of Education.

In-depth assessment of the sort described here may take several days or weeks and should be a major component in every CETA program. It is not a luxury item for occasional use. The few clients interviewed in the research who had experienced formal assessments felt that these had been very valuable. They had helped them to plan and were important in building self-confidence that there were jobs for which they had aptitude and interest.

4. Career Exploration

Recommendations for program planners and operators:

A. Require career exploration of all clients for their EDPs.
B. Include non-traditional role models in career exploration workshops or courses.
C. Include job forecast, salary potential, skill requirements and other specifics for a variety of jobs.
D. Consider contracting career exploration to outside groups such as women's resource centers.
E. Encourage clients to explore new directions for themselves.

A. Require career exploration of all clients for their EDPs.

Career exploration, like assessment, should be a required step in every client's experience in CETA. For much the same reasons as assessment, career exploration should be an enriching and option-producing experience for both women and men and for both experienced and inexperienced workers. Data from assessment, in combination with client ideas and goals considered during exploration, become the basis for the next step of employability planning (EDP).

B. Include non-traditional role models in career exploration workshops or courses. Career exploration should group its information for clients who share particular clusters of aptitudes or interests as determined during the assessment phase. The experience, perhaps organized as a course, might involve bringing in outside speakers from different career areas or taking clients to various work settings to work with people at their jobs. Movies and other media could be effectively incorporated into such a course which could also provide non-traditional role models. These models are especially important for women who may know of no non-traditionally employed women.

C. Include job forecast, salary potential, skill requirements, and other specifics for a variety of jobs. In addition to general information about different kinds of careers, specific job forecast information for the immediate area should be incorporated into the experience so that clients can know which jobs have good employment prospects in the immediate area. Included in the information should be present and projected income potential for different skill levels within jobs to assist clients to develop a realistic sense of their own earning potential in any particular job. A basic introduction to job families, the range of titles in each according to skill and income, and the setting in which each is performed would also increase the client's understanding of possible mobility options which accompany particular job choices.

All of this information is particularly valuable to women, many of whom know little about the world of work. It is also information which should encourage women to think about striving toward jobs which have some opportunity for advancement, rather than settling for jobs with no future or salary increase potential.

Such information in jobs is presently being developed by the

Colorado Occupational Career Information System (COSIS) of the state ES. It is a career information system which prime sponsors may wish to consider or modify for their client group.

D. Consider contracting career exploration to outside groups such as women's resource centers. Many high schools and junior colleges provide excellent career exploration courses and experiences for their students which might be incorporated into the CETA program as contracted services. Women's resource centers might be contracted with to provide such courses for all clients or specifically for women to encourage the use of an egalitarian approach to career exploration information. Staff for such courses should be chosen for their advocacy for women orientation and their ability to help women to freely chose for themselves based on sufficient information.

E. Encourage clients to explore new directions for themselves. Some clients may enter career exploration with a tentative sense of what kind of job they would ideally like to do and may finish the course with the same interest. However, the participant will have had time to examine some other options along the way and review assessment data which may then confirm or disconfirm the original choice. For women clients without career goals or much information about the world of work, such an experience should assist in developing some sense of particular jobs especially non-traditional jobs for women. The course might include field visits to work locations for those wanting additional exploration for a particular job.

In combination with the assessment data gathered previously, clients will then begin to match these two sets of information for use in the next step of developing an employability development plan. At the EDP level, clients begin to project themselves into a future ideal job.

5. Career Counseling Toward an EDP.

Recommendations for program planners and operators:
A. Require an EDP to be carefully developed for each client.
B. Allow clients to choose their career counselor and program sponsor.
C. Train staff to do non-sexist and non-racist counseling.
D. Include training and supportive service needs along with career goals in the EDP.
E. Consider the written EDP a client-program contract.

A. Require an EDP to be carefully developed for each client. The main purpose of this necessary phase of a client's experience in the program is to develop a plan for employment, or an employability development plan (EDP). Most prime sponsors need to give more emphasis to this segment in the program. This plan merges data from the assessment phase and information from the career exploration course. Career counseling brings together these two experiences into a formal plan of action for both client and program use.

B. Allow clients to choose their career counselor and program sponsor. If at all possible, clients should have some selection of their counselor in order to insure that they feel comfortable with this individual who is to serve as their sponsor throughout the rest of their program involvement. Counseling staff might be divided into two or more teams, one working with clients in the career exploration phase, and the others working with those coming out of career exploration according to client preference. In this manner, career exploration would be presented by one group of counselors from whom clients would declare their counselor preferences, if any, followed by individual sessions between clients and counselors as soon as these could be scheduled. Some sort of sharing between teaching and counseling roles, then, could occur for the counseling staff with perhaps a third rotation for counselors into some sort of in-service training or into intake work.

C. Train staff to do non-sexist and non-racist counseling. Women's

organizations could be contracted with to provide such in-service training either directly or through the sponsorship of DOL's Regional Training Center. Counselors in such training must examine their own attitudes toward women and work in light of the economic necessity of most women's work and women's needs to feel a sense of personal accomplishment and fulfillment through work. Counselors must learn to encourage and support women to strive for the best paying and most personally satisfying jobs they can get rather than encouraging them to settle for dead-end menial jobs so frequently considered "women's work." Counselors must also learn to assist women in considering themselves as permanent members of the work force rather than as temporarily employed even if there are gaps in women's employment due to child raising or other activity.

D. Include training and supportive service needs along with career goals in the EDP. The EDP might be approached and organized as follows, using an example of a traditional job choice desired by a hypothetical head-of-household woman in her EDP following assessment and career exploration:

a. desired job: secretary at $600+/month
b. job requirements for entry position: typing at 50 w.p.m., use of office machines, dictaphone skills, PBX, filing, etc.
c. basic education level needed: high school or GED
d. appearance and behavior: good grooming, social poise, communication skills, etc.
e. plan of action:
    1. complete GED at local adult evening education program (8 weeks)
    2. take secretary certificate program during day at local community college (1 semester's equivalent). Client has some background skills and may move through curriculum rapidly.
    3. enroll in short WE or OJT while taking pre-employment and job search CETA courses.
    4. take assertiveness training course at local women's resource center to develop more confidence (during 2-4 above).
    5. enter job search activity.
    6. secure desired job.
f. supportive service needs during and after CETA program involvement:
    1. child care for 1 and 3 year old children. CETA will arrange for Title XX paid (through Dept. of Social Services) care for

1 year old in licensed home located within walking distance of client's apartment. 3 year old will be enrolled at local community college's day care center for full-day care while mother takes classes there; fees will be provided on a scholarship basis by college. Client will move into sliding scale status with both programs after job placement and first pay check.

2. post-divorce personal counseling. CETA staff will assist in some counseling with client utilizing the free services of the local women's resource center for additional support group counseling.
3. transportation. Since client has no car, CETA will provide bus passes during program involvement until arrival of first pay check. Job development will center on locating a job near home or child's day care center at the college or one which is on a bus line near both.
4. legal services. Client's occasional legal needs surrounding child custody and property settlement from her divorce will be handled through the free legal services of a local PSE project, a legal cooperative.

The extensiveness of this EDP represents a more thorough effort than is known to exist in any Colorado prime sponsor, although it is an approach used in many special CETA funded women's programs. (See appendix listing of these.)

E. Consider the written EDP a client-program contract. The intention of this type of EDP, which specifies which skill and educational requirements are needed for the desired job and the exact method of acquiring these, is for it to become a contract between the client and the CETA program. The addition of the supportive service needs raises personal life problems to situations that can be managed and not be competitive to successful program completion. Although the records of such an EDP need not be extensive, they do serve to structure the client's involvement in the program and allow for both client and counselor to plan for a point of termination from the program. With the pre-EDP steps of assessment and career exploration, in combination with intensive counseling to create the EDP, the client will hopefully feel as though time and resources have been adequately extended to carry out the EDP.

Program involvement following the EDP can then take on a deliberativeness toward achieving the goals of the EDP.

6. Personal and Support Group Counseling.

Recommendations for program planners and operators.
A. Include personal along with career counseling.
B. Have staff and clients plan a regular schedule of counseling.
C. Have some CETA evening and Saturday hours to allow clients contact time with their counselors.
D. Allow EDPs to be modified as personal lives of clients change.
E. Encourage the formation of peer support groups.

A. Include personal along with career counseling. Because of the type of EDP proposed, the distinction between personal and vocational counseling is not being made, since one's capacity to successfully be trained and remain gainfully employed depends in many cases on the degree of stability in one's personal life as reflected through the identified supportive service needs in the EDP. This is particularly true for women clients whose capacity to successfully train and become employed is very related to the quality of child care arrangements, availability of transportation, sense of personal stability following a divorce, etc.

Staff who work with clients on their EDPs should also be expected to do some personal counseling along the way and to serve as the client's sponsor or "homebase" throughout the rest of that client's program participation. If the client and counselor determine that more extensive types of personal or mental health counseling are needed, additional supportive service needs for this can be added to the EDP and the client given appropriate referrals to free or sliding-scale fee community services.

B. Have staff and clients plan a regular schedule of counseling. As the EDP intensive vocational/personal counseling phase is completed, and the client prepares to enter the next component planned in the EDP, the counselor and client should decide upon a regular schedule of follow-

up meetings to talk about the client's progress, any new problems or supportive service needs which may emerge, etc. These may be every few days for a client who needs lots of support, at least initially, to every few weeks for clients who prefer to be left on their own. Women may very well be those clients needing additional support and encouragement, especially displaced homemaker women who have not considered training or employment until quite recently.

D. Allow EDPs to be modified as personal lives of clients change. Throughout the meeting schedule of counseling being carried on during training and preparation for job placement, the EDP may be modified as needed to better suit the client's needs. All along the way, every effort should be made to utilize existing non-CETA funded services in the community, rather than CETA funded services, in order to save unnecessary expenditures from the scarce CETA funds. (See supportive services discussion later in this chapter.)

E. Encourage the formation of peer support groups. Client support groups may be formed for those clients who desire the experience of peer sharing. Several clients with the same counselor might be grouped by that counselor for occasional group meetings to discuss common experiences and plans. Referral might also be made to local community groups, such as those sponsored by mental health facilities or women's resource centers. Such women's groups often result in a building of a sense of peer support and a network for friendship and exchange of such services as child care, transportation, etc. In urban areas where many clients do not have extended family members or close friends, this kind of group may be useful in learning to build a sense of interdependence through a network separate from the CETA staff. While CETA staff might facilitate the formation of such a group, their presence and leadership should be limited so that the participants

can develop their own sense of group.

7. Classroom Vocational Education

Recommendations for program planners and operators:
A. Include classroom training only when an EDP calls for it.
B. Contract training to open-entry and open-exit institutions with individualized instruction.
C. Contract training to a wide range of institutions according to client supportive service and other needs.
D. Encourage individual referral rather than class sized projects for most training.
E. Create class sized projects for training women in non-traditional skills.
F. Use competitive bidding to stimulate vocational education creativity.
G. Support Vocational Education Act efforts to desegregate vocational training on the basis of sex.

A. Include classroom training only when an EDP calls for it. This component may or may not be experienced by every client since it will depend upon the training needs for individual participants identified in their EDPs For those taking vocational training, it is one of a series of activities planned in the EDP toward the client's choice of job fields and may be followed by OJT or other program component. The client thus enters into the training with assessment data already supporting the choice and career exploration information setting the level of client expectation for the type of work involved from this training and the available jobs in the area. With extensive preparation for the training experience, clients should be able to enter the training with realistic expectations of what will be involved and with a good sense of backup from their CETA counselors throughout that segment of their EDP.

CETA programs, then, should not enroll everyone in classroom training because of its easy availability as a program option.

B. Contract training to open-entry and open-exit institutions with individualized instruction. The institution for such training would, ideally, be run on an open-entry and open-exit plan to allow clients

to enroll as they are ready for courses in the progress of their EDPs. Subject areas could be broken down into smaller components with encouragement given to participants to challenge any section which is a review of previously acquired skills in order to move along to new learning components. The training sections required for any particular certificate (such as the previously given example of secretary) might usually take a certain time period to complete. Yet, if an especially well motivated client, who may also have some background skills, would prefer to move through the training at a faster face, this should be possible. On the other hand, some clients may need to approach the learning process at a slower pace or have the opportunity to stay with one section for a longer period of time in order to have a true mastery of the skills before moving into the next section. This should be possible, too. Some clients may prefer to do vocational training on a part-time basis in order to meet family needs, keep a part-time job, or take part in some other experience, such as extensive mental health counseling. With such an individualized learning system for vocational instruction, clients would be able to move at their own pace through the curriculum designed for their own particular job goal.

C. Contract training to a wide range of institutions according to client supportive service and other needs. The choice of institution for each client is important. Although the 5% CETA vocational education funds for each prime sponsor may be administered in such a way as to encourage enrollment at only a limited range of local institutions, the counseling staff working with clients to develop EDPs should have complete information on all training and educational institutions in the area. Some clients may want to attend public community colleges and may find such a

large setting uncomfortable. For other women or men clients, if there are private or public training institutions which are smaller and even more personalized, this may suit their needs better. For women, the availability of transportation to training may also influence the choice of institutions, as may be the availability of child care facilities at a particular institution. Supportive service needs, then, continue to be an influence on the type of setting located for women's training.

D. Encourage individual referral rather than class sized projects for most training. Although it is perhaps administratively efficient to have class sized projects for training of CETA clients, it may be more in the clients' interests to allow individual referral types of training whenever possible. Clients may feel coerced into joining the group project classes because there are openings rather than because it is what they want. Women have often been recruited into such classes for clerical upgrade or other traditional job area without any previous CETA program experience or counseling toward an EDP. Because careful planning has gone into the EDP prior to vocational training, and because the client has a backup "homebase" counselor in the CETA program for any additional assistance, clients may want the independence of being a "regular" student, integrated in with others, rather than be singled out for a special class at the training institution.

E. Create class sized projects for training women in non-traditional skills. In order to encourage women to enter non-traditional vocational training, which is likely to be a mostly male experience, all women's preparatory classes taught by women would be very useful. In this supportive setting, women can learn the names and uses of basic tools, for instance, which may be assumed to be common knowledge in machinist training. They

can learn to feel comfortable with the "tools of their trade" and become psychologically ready for more specific training. Also, women's sections (for CETA and non-CETA women) of shop math, blue print reading, drafting, or other skill area would be helpful background for women. Many men have had some advance contact with these areas before beginning classes whether informally as a part of their upbringing or through shop or other classes during their public school years. Women need comparable background skills.

F. Use competitive bidding to stimulate vocational educational creativity. Rather than accepting curriculum as it is, prime sponsors can influence the creation of the more individualized, creative curriculum described here through using competitive bidding, if possible, to require training institutions to respond to these priorities. If institutions cannot or will not provide such curricula, CETA programs can put their training dollars elsewhere. CETA staff could do some of this influencing by working through the State Board for Community Colleges and Occupational Ecucation's CETA representative to their area, who in turn might work with local training institutions to encourage more experimental and open teaching approaches which will better serve client training needs.

G. Support Vocational Education Act efforts to desegregate vocational training on the basis of sex. With planning going on at the state and local levels concerning how the 1976 Amendments to the VEA are to be implemented, prime sponsors should keep themselves informed on the progress of this work. The Amendments address, in part, the need to modify curriculum and policies of institutions in order to encourage more women and men to enter non-traditional career areas. Special kinds of services and programs may be developed which could also serve CETA clients, especially those desiring non-traditional career training.

Although classroom vocational training has its place as a part of client EDPs, it is not the only way for clients to acquire skills and should not be overused in the EDP merely because training institutions are available and courses are easier in some cases to arrange than OJTs or other components. Other program components alone or in some combination with classroom training may better suit client needs than enrolling clients in long and complex vocational education programs.

8. Adult Basic Education and English as a Second Language. (ABE-ESL)

Recommendations for program planners and operators:
A. Include ABE-ESL referrals when individual EDPs call for them.
B. Encourage educational institutions to create special ABE-ESL projects which could also serve CETA clients.
C. Utilize ABE and ESL "grads" to work with new enrollees.

A. Include ABE-ESL referrals when individual EDPs call for them.

Although CETA program staff often complain that they are not in the business of doing remedial education, if some attention is not paid to client educational needs and deficiencies, the clients may be prevented from having successful experiences with vocational training and job retention.

While recognizing the importance of making up any educational deficiencies which client EDPs (based on assessment information) indicate are in need of attention for their particular career goal, CETA programs very likely will not need to provide these services directly themselves. If program staff have complete and correct information on local education programs for adults and are willing to pay program enrollee stipends to clients while they are participating, clients can add these experiences as a part of their EDPs. Public libraries often sponsor tutorial programs, public school systems often have evening adult education programs, free universities provide special courses in reading and math as a part of their varied curricula, etc. Depending on the individual's educational needs, one such

service in the community may be the proper referral.

B. Encourage educational institutions to create special ABE-ESL projects which could also serve CETA clients. If existing adult basic education and English as a second language services are felt to be too limited, in the opinion of informed CETA staff, the prime sponsor may wish to contract with a local college or other educational institution to develop a specialized, individually paced course for CETA clients on a one-to-one basis. This could be done with the same kind of open-entry, open-exit program as the proposed vocational education. Local educational institutions might be encouraged to attract in special grant money to create new ABE programs and experimental learning modules which could serve CETA and other clients in the community. Ideally, this could be done at no cost to the CETA program except for stipends to clients to attend.

C. Utilize ABE-ESL "grads" to work with new enrollees. Another idea would be to utilize CETA program ABE and ESL "graduates" to return to CETA in the form of volunteer tutors for more newly entered clients with ABE or ESL needs respectively. This might be done through a buddy system (or whatever name is considered to be more appropriate) where newly entered clients would have a role model to assist them in their progress toward job readiness and economic independence. For ESL clients, the same first language speakers could be paired with encouragement given to both to practice their English together and still enjoy one another's conversation in the native tongue.

9. Pre-employment Courses

Recommendations for program planners and operators:
A. Provide information on employer expectations to clients as a required component.
B. Provide special courses for women seeking non-traditional work.

A. Provide information on employer expectations to clients as a required component for all clients. Program staffs can develop various in-house courses for client participation prior to their seeking employment. Such an example would be a "jobology" course, as OIC terms it, which includes an introduction to proper work behavior and dress, orientation to employer expectations of punctuality and regular attendance, role playing practice in accepting supervision, and in general, teaching responsibility and understanding of the commitments required in accepting and keeping a job. Such an educational effort may successfully be accomplished in a group setting and may include employers coming to make presentations, civil rights specialists teaching job myths and rights, union leaders presenting the case for organized labor, and tax and financial experts explaining how to manage money earned on the job.

The course could be combined with career exploration earlier in the client's program involvement or later with a job development course. It would especially be useful for women who have never had jobs, to individuals who have had difficulty in keeping jobs, and to individuals who have not worked for an extended period of time and desire some brush-up on expected work behavior.

The course should include discussion of the relative advantages and disadvantages of being employed, such as a regular income in exchange for less free time. Such courses should teach a work orientation and a recognition that personal values will have to be resorted if necessary to retain employment. Work should be approached in such courses in the context

of time and life management.

B. Provide special courses for women seeking non-traditional work. In addition to the information covered in the main pre-employment course, women seeking non-traditional work need additional coaching. Since few women have entered such jobs, these women need to be ready to help establish appropriate expectations for their performance on the job. They need to be ready to handle any harrassment or sexual advances, for instance, and how to end such interference to their job performance. This may require legal information on their recourse in such situations as well as every day skills in learning to survive and hopefully, gain respect and acceptance in a male dominated work setting.

For many women entering non-traditional work, there are uncertainties regarding their self-images as women in such new roles. There may be anxieties about how peers and family members will relate to them quite separate from the treatment at the actual work site. Contact with positive role model women may help as well as the provision of women problem solving and support groups once employed for the sharing of common experiences. Also, women entering non-traditional employment should especially be encouraged to take assertiveness training. (See following discussion.)

This course could be offered in-house or contracted to a women's organization which has experience in non-traditional work. Better Jobs for Women in Denver would be such as example.

10. Assertiveness and Self-Confidence Training

Recommendations to program planners and operators:
A. Provide assertiveness and self-confidence courses in the program.
B. Recognize that such courses are particularly valuable for women.

A. Provide assertiveness and self-confidence courses in the program. Many women, and perhaps many men, lack skills needed to provide leadership

or effective communication of their own ideas in work and other life settings. Many colleges and women's resource centers now offer such courses in an effort to teach one how to gain control over one's own behavior and to learn to have impact in decision making settings. Contracts could be made for such courses to such institutions or these could be developed on an in-house basis.

B. Recognize that such courses are particularly valuable for women. Assertiveness and confidence building training are often unique needs of women clients. After such training, women often report heightened self-confidence for subsequent training and employment. Displaced homemakers may particularly benefit from such courses since they face the special problems of re-rentry and often feel quite overwhelmed by the experience. It is also an experience which can teach some achievement and success orientation, indicate the various women's CETA special programs (see Appendix listing of these), rather than encouraging women to continue with traditional coping and passive behaviors.

11. Community Services

Recommendations for program planners and operators:
A. Offer a course on community services for clients, staff, and the community.
B. Use such courses to improve supportive services available to clients.
C. Publicize the course internally and through outside media.

A. Offer a course on community services for clients, staff, and the community. For clients who have not worked and for those whose incomes were most recently through welfare, there may be a need for information on how to make "the system" serve one's own individual needs. Such a course might run in the evenings as a community service project, with staff and participating employers also invited, as it would deal with a different agency or service each night. Child care centers, food coops,

public housing, services through the Department of Social Services, just to name a few, might each take one night's program and present an open-house and program as a part of that evening's session. The purpose of the program series would be to educate clients, staff, and interested community members to the kinds of services available in the area, especially those which are free or low-cost, which can assist in making limited earning go farther. A skillful use of such community services can assist clients to remain economically self-sufficient once leaving the CETA program. Such programs would also provide in-service training for staff doing supportive service, income counseling, and other services in the program. (See supportive services section later in this chapter.)

B. Use such courses to improve supportive services available to clients. Such a program series would also contribute to the CETA program's public relations and interagency rapport since CETA would be, in effect, giving leadership to interagency coordination and information exchange. Meanwhile, clients would be acquiring valuable information about how to solve their own needs through existing community organizations with staff learning how to support clients in these efforts.

C. Publicize the course internally and through outside media. Such course programs could be publicized internally through a CETA staff and clients newsletter which could be posted and/or mailed with client allowance or salary checks. The media might be encouraged to cover such programs as public information spots, which would further educate the community to its own resources. If staff time is limited to do the work involved, WE or PSE positions could be created to staff the project, which would further educate the participating clients. A newsletter could also include feature stories of important program accomplishments or have

particular clients or staff featured as special topic articles. This would not only contribute to better communication within the CETA program, but it would recognize individual and program accomplishments, as well as publicizing any other CETA activity taking place. This would solve one of CETA's problems in trying to become well known in the community.

12. On-the-Job Training

Recommendations for program planners and operators:
A. Use OJT only when called for in EDPs.
B. Develop both individual and group OJTs.
C. Maintain ongoing public relations with employers for OJT development.
D. Learn from WIN and VA OJT experiences.

A. Use OJT only when called for in EDPs. OJT is another program option to be incorporated where appropriate into individual EDPs of clients. OJTs are perhaps most effectively used where some skills are possessed by the clients and an on-site working and learning experience would be the most efficient way to acquire the balance of skills needed for successful employment. Clients without any work skills might require some classroom training prior to entering an OJT since, once the OJT is completed, the client usually becomes a regular employee of that employer and may not then be eligible for vocational or other training experiences through CETA because of being employed and having an income.

OJTs can also be developed for the client to work on a part-time basis, perhaps in combination with part-time classroom training or simply as a part-time training experience. For women, such part-time options, at least initially, would be helpful since many women who are re-entering the job market may need time to gradually adjust to the demands of a job and the life and supportive service changes which accompany working.

OJTs can be effectively used as the end point of a series of activities leading up to employment. If the OJT can be developed in a good

paying job, the client then enters the employment market with a credible salary history and improved chances for mobility. It is an effective training setting for those desiring skills not taught in a classroom setting as well as for those with classroom skills who only desire work experience with a commitment of the part of the employer to hire them at the end of the training period.

Some experimentation could be done with OJTs with an optional commitment to hire based on the client's performance. The job experience with a private employer would still be possible and might make OJT development easier with employers. Women clients often need such work experience which they could get in such an arrangement, whether kept on as permanent employees or not.

B. Develop both individual and group OJTs. While OJTs are perhaps best when individually developed for particular clients as a part of their EDPs, there are situations where group OJTs may be useful. If employers will release line supervisors in the work setting to do some teaching, effective group instruction can occur on the equipment used by that employer. Some programs are concluding that the development of group OJTs with a requirement to hire at the end of the training is an efficient way to serve a whole group of clients and save the time and effort required to develop individual OJTs for each client. As long as the OJT experience is consistent with a group of clients' EDPs, such group experiences can be quite successful. Such group contracts for non-traditional jobs for women would have the added advantage of the women having each other as a support group throughout the training and early employment experience.

Group contracts can also be used as a part of an economic development effort on the part of the prime sponsor since new companies may gladly take

on the additional responsibilities of training in return for a trained work force and some subsidy to assist in their fledging financial enterprise. In economically depressed areas, such economic stimulation through group OJTs benefits women especially, since it means that new jobs are available that perhaps only they, through group OJT contracts, will have the expertise for.

C. Maintain ongoing public relations with employers for OJT development. An on-going public relations effort with the community and its employers should have direct payoff as OJTs are developed for particular clients or for groups of clients. Employers need to hear about the success stories of other employers before entering into the training venture and an effort should be made to facilitate this sharing between employers. With some publicity before such groups as the local Chamber of Commerce and other employer organizations, the CETA program may find itself in the fortunate situation of having more employers approaching the program for a trainee/assistant, which could then be matched with the EDP needs of clients desiring OJTs. OJTs in such new and expanding fields as pollution monitoring and control or energy development might more easily be developed. Again, if women clients can have such OJT experiences, they would have a competitive edge in future employment in these fields.

D. Learn from WIN and VA OJT experiences. Local CETA programs may want to study the particular way that WIN and VA OJTs are handled to borrow any of their successful features concerning payment to employers, training and incentives for clients, etc. Also, CETA staff and staff of the other two programs may wish to coordinate their efforts to create OJTs in the community, but in a way to not oversaturate the employer

market for requests to participate. Again, some interagency coordination should pay off in improved services to clients.

Some experimentation would be possible in allowing clients to develop their own OJTs with staff assistance. This would add greater incentive to the client to find the type of position s/he wants and might encourage the employer to feel a sense of having chosen the person as an employee in training. Several of the national CETA funded women's programs are experimenting with this approach. (see Appendix listing of these programs.)

13. Work Experience (WE)

Recommendations for program planners and operators:
A. Use WE only when called for in client EDPs.
B. Encourage WE for women without recent job experience.
C. Reward successful WE clients.

A. Use WE only when called for in client EDPs. As with the other optional components for client participation, enrollment in a WE position should occur only in cases where it is felt to important in the EDP of an individual client. As a short-term job which is fully subsidized by CETA funds in a public or non-profit private organization, the experience is valuable only in the context of what precedes and and follows it as a part of the EDP. Although used for summer and in-school youth jobs, the main use of concern in the research was its use for adult women for work experience since it can be a valuable component for adult women's use.

B. Encourage WE for women without recent job experience. Many women, such as displaced homemakers, may benefit from the experience of a WE. With such women, once an EDP is defined and skill needs identified, WE may be an appropriate follow-up to classroom training before entering the job market. Or, it may be appropriate for a woman with work skills who has not used them in some time and needs a job for "brush up" of these skills before seeking an unsubsidized job. The participating woman needs

good pre-employment information before entering the experience and regular evaluation while in it regarding her work skills in behavior. In such a use, WE becomes a trial job from which one can learn appropriate work skills in a relatively sheltered setting of a short term job. WE should be a period of receiving good feedback which will be important learning for future jobs.

C. Reward succesful WE clients.

For adults, some experimentation with incentives for good work could be done. The usual contract with an employer for WE is that there is no commitment to hire the individual at the end of the funded period. This can lead the employer to poorly supervise the employee and the employee to not take the job as seriously as an unsubsidized job of a more permanent nature. The possibility that excellent performance might lead to permanent employment with that employer could be established in order for the work experience to be regarded as a "real job" rather than as a experience in learning about a job. The possibility of extension might also be attractive to employers who could then choose from several WE participants for staffing of the continued position.

If the work experience is needed in other than a public or private non-profit work setting, OJT should be considered as a possible substitute for direct WE. Whether the woman is hired under either type of contract, the experience of having had a job is valuable and the skills and work habits acquired will hopefully benefit her employability in the future.

14. Public Service Employment (PSE)

Recommendations for program planners and operators:
A. Select PSE applicants on the basis of need.
B. Follow the CETA law's requirements for PSEs.
C. Incorporate PSEs into client EDPs where appropriate.
D. Publicize the availability of PSE funds and evaluate proposals stringently.

E. Fund PSE positions to provide creative services to CETA clients and the community.
F. Assist funded organizations to financially continue the PSE position themselves.
G. Encourage political officials to offer creative ideas for PSE use.

A. Select PSE applicants on the basis of need. The funds allocated between Titles II and VI in local prime sponsor programs are often more than half of the total CETA funding available to local programs. While present CETA regulations make only modest demands on programs for client selection criteria, such as unemployment for more than 30 days or Unemployment Insurance exhaustee, local programs could do much more to insure that these fully subsidized jobs reach those most in need. Most CETA programs handle selection of participants for PSE positions in an entirely different manner from selection for Title I programs. The need is for all of the Titles to be unified into a single CETA program, rather than have several CETA programs, with one unified form of selecting clients and participants. PSE applicants should be selected by the same kind of criteria used to determine program eligibility in the other Titles' programs. (See earlier planning council discussion.) If this is done, women would receive PSE proportionately to their economic and unemployment need within the population, which is not now the case since PSEs are held predominately by males, veterans, and college graduates in many areas.

B. Follow the CETA law's requirements for PSEs. The regulations governing use of PSE funds require that prime sponsors prohibit discrimination in the hiring and allocation of funds. Further, patronage and nepotism are prohibited as are direct political activities by PSE employees. There is a requirement that "maintenance of effort" be shown on the part of employers with PSEs with an effort to "transition" these individuals on PSEs into the regular work force of that organization.

The regulations and law also specify that PSE funding should be available for private non-profit organizations although generally the funds are used mainly in public agencies. Finally, PSE funds are to be used to create services which fill significant public service needs.

If all of these requirements were followed, women would be getting qualitatively different kinds of service from PSE positions. Individual women would be getting hired in greater numbers and not discriminated against in the better paying and more professional jobs created with PSE dollars or relegated to the traditional female occupations. And, women's organizations would be getting their share of PSE positions to carry out their public service projects which would benefit even greater numbers of women. Women, then, need to see that the law is followed for use of PSE funds.

C. Incorporate PSEs into client EDPs where appropriate. With a unified program which includes PSEs with the other components of the program, PSE jobs could become an option which could be written into an EDP of an individual client and a PSE position developed for an individual client if appropriate. Although not all economically and culturally disadvantaged people may have the skills and experience to compete for professional PSE's, they should be given first priority for PSE positions over the financially poor who have extensive educational and employment histories and may be temporarily unemployed. If professional level positions are to be present in the PSE collection, it might be assumed that some positions will go to non-disadvantaged people but least those in greatest need among the applicants should still be given the highest priority for hiring.

D. Publicize the availability of PSE funds and evaluate proposals

stringently. Some programs are getting a quality range of PSE jobs, most of which can be filled by program participants by doing extensive publicity of the funding's availability in their communities. For the most recent round of Title VI funds, some programs have issued formal requests for proposals in order to have as wide a range of positions and projects for funding as possible. Effort should be made to make all eligible public and private non-profit organizations aware of the availability of funding. Evaluation of the many applications can then be made on a number of criteria, such as the quality of the job in terms of career building for clients, the salary offered, the degree of match between the job skills required and those of program participants, and the likelihood of the public or private non-profit organization being able to continue the person as a regular employee at the end of the PSE funding period. In this way, placing a program participant in such a job is not such a risk since there is every evidence of a quality experience, good salary, etc. with future employment at that location, rather than the possibility of placing someone at that location in a dead-end job.

E. Fund PSE positions to provide creative services to CETA clients and the community. PSEs can be used to develop CETA interagency coordination. A PSE can be created in an agency (or a whole new agency created) to provide medical, legal, mental health, child care, or other service to CETA clients, perhaps arranged with a non-financial agreement in return for the PSE funding. Colorado Springs follows essentially this plan to arrange for some supportive services. If there are gaps in available supportive service agencies, group PSE projects can be solicited which will provided the needed services for CETA clients as well as other people in the community. While PSEs can, of course, be used to subsidize existing municipal services in such areas as fire and police protection,

there is every opportunity for a more creative use of PSEs to do new services and projects for the community. With some interagency planning with the Community Services Administration, for instance, or other organization providing materials, PSEs could be used to winterize homes, build parks and recreation areas, or otherwise add permanent public resources and facilities to local areas. The recent Carter plan for public works projects may realize this in part, but only if prime sponsors add their own creative ideas for their local use of PSE funds.

F. Assist funded organizations to financially continue the PSE position themselves. Because many PSE funded agencies have difficulty arranging their budgets to absorb the PSE positions after the period of funding ends, which makes a PSE jobs highly unstable from the point of view of the client, one CETA staff person (or another PSE) could be assigned the task of doing fund raising for public and private non-profit organizations receiving PSE positions. This person could scout available grants and foundations for support, and work with such organizations to develop funding for themselves in order to wean them from over-reliance on CETA funds. The same person, or another staff member, could also be given the assignment of assisting the PSE individuals to plan for their continuation with that employer, whether through taking personnel system examinations, acquiring additional skills to be qualified for entry at a higher level in that system of that organization, or planning for a job search in related jobs based on that PSE experience.

G. Encourage political officials to offer creative ideas for PSE use. Political officials should be involved in the planning and evaluating of PSE requests from community organizations. If they have particular priorities for funding, these should be public information at the time of position application by local organizations to avoid a situation

of pre-selection of funded agencies occurring through political influence. The process should be open and positions awarded on the basis of merit of the application. Staff, planning councils, and interested community groups can help to give creative ideas for use of PSE funds to political officials and can be a part of the decision making process of defining community needs. Women should join into this process in order for women's needs and projects to be recognized and funded.

15. Job Development

Recommendations for program planners and operators:
A. Vary effort according to component.
B. Require job development course for all program participants.
C. Follow-up course with individualized job development service.
D. Prepare clients to do their own job development with staff assistance.

A. Vary effort according to component. The form that job development takes will vary according to the form that an individual's EDP takes. For clients in OJT positions, carefully written contracts with employers (where the client will want to stay) result in the client being job placed the end of the period of subsidized funding. For those clients whose EDP includes a PSE position, since every effort should be made to select PSE positions based on their likelihood of being permanently continued, most of these clients will also not need direct job development. Job development, then, will mainly be a component that clients completing vocational training and those clients finishing PSE or WE positions which have not resulted in permanent jobs, will most need.

B. Require job development course for all program participants. Although not every client will appear to need a formal component enrollment for job development, there are experiences which should be organized as a group course which should be given to all clients. It could be directed toward both those directly looking for jobs and for those who may need to

have such skills for their future job hunting efforts. Such a course might be organized as follows:

1. Job Information. Clients need information on where to go to look for jobs both now and in the future. This would include discussion of the services and limitations of such sources as the ES, want-ads, trade magazines, public personnel system listings, placement offices of educational institutions, private employment agencies, etc. This would also include local information concerning which employers are hiring and expanding their work forces.

2. Applications and Resumes. Coaching, with individualized assistance in developing a good collection of personal documents needed for application purposes, could occur which would include application and resume skills. This would include help in choosing references, establishing placement folders where appropriate with placement offices of training institutions, and generally learning to successfully represent one's self in writing.

3. Interviewing and Follow-up. This portion of the course would include role-playing, videotaped feedback, and other skill training in how to effectively interview for jobs and be prepared for the types of questions which may occur during an interview. After an interview for an actual job opening, clients would be assisted in learning to evaluate the interview and judge what the appropriate follow-up should be with that employer to facilitate getting hired. Also included would be suggestions for how to keep accurate records of the status of multiple applications as a part of the application and follow-up steps, whether requested references or other documents have been sent, etc.

Such information and training is particularly vital to women who often lack both. Displaced homemakers especially would benefit from such an experience as they prepare for their re-entry to the world of paid employment.

C. Follow-up the course with individualized job development service for each client. After being exposed to these issues in a group setting and at a general level for all occupations, clients should meet individually with a job development staff member to plan for their own individualized job search. As a specific extension of the EDP, good records should be kept of this job development process for both program and client use.

A structured check-in system of clients informing staff of their efforts would be planned with periodic sessions for evaluation of the

efforts by the client to date. Since there would be no need to duplicate the services of the ES, CETA programs should not generally be soliciting their own job listing which are not also listed with the ES, although it might be helpful to have ES microfilms available for client use in the CETA offices in cases where CETA offices are not in the same location with the ES. Since the ES would be only one of the information locations for clients' job search efforts, the staff member would work with the client on all information sources. In every way, staff should work with the clients in a behind-the-scenes role whenever possible with the client actually doing the calling for interviews and follow-up status of applications, when they are ready for these steps. This is especially important for women to develop the necessary confidence in themselves but in a supported setting with available staff assistance when needed.

D. Prepare clients to do their own job development with staff assistance. The purpose of job development as a component is to teach clients the necessary skills to do their own job development in the future rather than always needing the assistance of CETA or some related program to locate jobs for them. To effectively be able to do this, clients will need careful group and individualized attention to complete this final step of locating employment in their chosen field. While it is tempting for job development staff to arrange interview for clients and even solicit job listings for the CETA program which are not shared with other organizations, this approach may not be helping the client to develop the needed independence.

Job development staff do have a particular function. They can have information on the local labor market and the types of hiring going on in order to assist clients in investing their job search energies most efficiently. They can specifically help women and minorities by keeping

current on the affirmative action needs of local employers and where applications are likely to be favorably received.

The focus of job development should be on clients receiving assistance in getting jobs for themselves, rather than the program "placing" individuals in jobs with the implied client passivity which accompanies this approach. Direct staff placement, then, is a last resort activity in such a program and should not be needed if the client has received sufficient skill training to do her/his own job development.

Some non-Colorado programs are having successful experiences in forming clients into job clubs, an idea first developed in Anna, Illinois. Each club has an office telephone number and area in the CETA offices for use by club members. Those clients without telephones can use this telephone to make job inquiry calls, arrange interviews, and receive messages. Club members are encouraged to stagger their use of the telephone to provide for the presence of at least one club member at the telephone during the day hours to serve as message taker for the others who may be out on interviews, etc. The group meets together for role playing and other skill training as needed from staff members. And, to build incentive to locate a job as quickly as possible, club members are paid for six hours of job search "work" a day for a maximum number of weeks, usually two. Placement rates have been high from these programs and women have especially benefited from the supportive experience of group members all helping each other. (See appendix listing of special national CETA programs for women.)

16. Employer Programs

Recommendations for program planners and operators:
A. Design CETA orientation sessions for OJT, WE, and PSE employers.
B. Sensitize employers to client needs, especially those of women.
C. Encourage employers to give feedback to the program.

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A. Design CETA orientation sessions for OJT, WE, and PSE employers. A special program focus needs to be given to employers involved in the OJT, WE, and PSE components. Usually their recruitment and orientation is handled on a one-to-one basis which, while personalized, may not be the most efficient or thorough way to accomplish either task. Employers, especially supervisors working with clients, need orientation about what CETA is intended to do both nationally and at the local levels. Brochures may assist in this process and group sessions might even be better in order for employers to feel that they are not the only ones working with the program.

B. Sensitize employers to client needs, especially those of women. The criteria for selection of CETA clients needs to be discussed with employers in order to sensitive them to the kinds of personal life situations of their subsidized employees. It is especially important that employers and supervisors develop awareness of women's unique needs which must be resolved in order for them to be effective workers. Special sensitizing may be needed for employers taking on women employees in non-traditional jobs in order to make this as successful experience as possible for the individual women. In addition, employers may need assistance in learning to conduct non-sexist interviews, training, and supervision which would be helpful to the women clients assigned to their locations.

Employers, according to those interviewed in this study, can often see problem areas developing with program participants. If these were reported to staff, counseling or referral to other community organizations might help in solving the problem. Yet, many employers indicated that they sometimes hesitate to give feedback of this sort to CETA staff for fear of it reflecting poorly on the client or on their own efforts to work with that individual, when it may be the very feedback needed in order to

improve client work experience for other kinds of jobs. Research interviews were conducted with employers who were aware that their CETA employees had drug problems or difficulty in keeping regular child care, but were hesitant to approach anyone directly about it, including the client, figuring that they somehow were expected to be "tolerant" of such problems rather than take part in helping to solve the need.

C. Encourage employers to give feedback to the program. Interviewed employers were often eager to have their ideas considered but indicated that they had no opportunity to share these with CETA staff or program planners. The most frequent suggestion was that CETA programs should seek higher visibility in the employer community through improved public relations and public information campaigns. Others suggested that employers need to be included in planning for increased female participation in non-traditional jobs and the kinds of services CETA and employers should provide to facilitate this effort.(See employer discussion on each site.)

If participating employers can know staff and one another at some level, they may more readily know how to give the kind of supervision and feedback to the program needed to work effectively with participants. This kind of relationship will require additional efforts on the part of CETA staff members. Women will benefit if employers and staff are in a regular state of communication over their needs and all aspects of program which relate to employers.

E. Management Information System (MIS)

Recommendations for program planners and operators:
1. Detail client status for all participants in the MIS.
2. Provide descriptive data for each component in the MIS.
3. Provide affirmative action monitoring data in the MIS.
4. Collect and record supportive service needs data in the MIS.
5. Train staff to collect and record accurate data.

Although MIS efforts vary by prime sponsor, despite efforts by DOL to make these systems uniform, there are basic program needs which a good MIS system can fulfill. These would include but not be limited to such information as the recommendations suggest, and should be information that local women's groups and other monitoring efforts should have upon request.

1. Detail client status for all participants in the MIS. At the very least, the MIS system should be able to determine the exact status and location of every client at all times. Since such systems are perhaps best handled by computer, a computer capacity to produce a client's program history printout is also helpful as well as being able to generate other specific kinds of data when requested. Examples of such data would be the numbers of clients in every program category and their demographic characteristics, which would facilitate monitoring where the women are in that program.

2. Provide descriptive data for each component in the MIS. Data for planning use should be available from the MIS system. Such questions as the number and percentage of clients completing any given component, the percentage of clients hired from their OJT/WE/PSE component, the average length of stay in the program, the pre- and post-program salaries, the cost per placement, etc. should be answerable from the MIS. Such information should also be broken down by demographic characteristics, again for facility in monitoring program impact on women.

3. Provide affirmative action monitoring data in the MIS. Data on client characteristics (sex, race, age, ethnic heritage, etc.) should be incorporated throughout the MIS in order to have this information accompany any other collection of information requested (see #1 and #2 above.) Without such information, there is no way to determine if there is a patterning of services based on sex, race, or other characteristic.

Such information would allow the monitoring of affirmative action plans and accomplishments in very clear form.

4. Collect and record supportive service needs data in the MIS. Cumulative data should be maintained on the kind and number of supportive services needs identified in client EDPs and the kinds and numbers of referrals or services that were provided by the CETA program. This needs assessment data then can serve as a basis to determine which needs exist and the approximate level of demand for such services. CETA supportive service funds can then be planned for, or efforts made to contract these services to other community agencies. This would particularly assist women's supportive service needs since cumulative information on needs should lead to improved program response to these needs.

5. Train staff to collect and record accurate data. As with any computerized system, the data obtained are only as good as what is provided for storage in the system. Staff should be trained to obtain accurate data during the intake and EDP stages since these are the main points in the system when clients provide information about themselves. Questions to determine these data, as previously discussed under other section, need to elicit complete information needed for the various kinds of program management questions which need accurate answers. Good internal data are one part of the information needed to effectively evaluate and plan, which should be the goal of the MIS.

F. Follow-up and Evaluation

Recommendations for program planners and operators:
1. Utilize counselors as the main follow-up staff.
2. Follow-up all participants regardless of termination status.
3. Conduct exit interviews with all clients.
4. Try different approaches to locating clients for follow-up.
5. Provide opportunities for the staff to evaluate the program and each other.

1. Utilize counselors as the main follow-up staff. In terms of follow-up, clients in all stages of program involvement should be followed by their counselor with whom they wrote their EDPs. It is assumed that most clients will successfully complete their EDPs and will continue to work with program staff until placement in an unsubsidized job occurs. If clients have completed all phases of their EDPs except job placement, for purposes of the MIS they should be considered active clients since they are still in a state of program involvement as they job develop. With counselors working carefully with clients all along the way, drop-outs and other negative terminations should be minimized although a few will still undoubtedly occur. After clients leave the program, the counselor is the single staff member best known to them and the obvious one to do any follow-up activity with them.

2. Follow-up all participants regardless of termination status. The follow-up system should follow any client who has left the program for whatever reason, rather than just following that portion of the client group who enter unsubsidized employment, the usual program focus at present. Those leaving the program prior to taking jobs may have good reasons for leaving which may or may not be related to the quality of the CETA program, but these particular reasons should be determined and recorded in the MIS.

In the case of women, various personal life and supportive service crises influence the decision to leave or complete the program. The CETA program has the responsibility to follow-up and assist anyone who has once been a program participant and to accurately record the true reasons for termination. These reasons need to be given rather than "lumping" most clients under such negative termination categories as "refused to continue" or "unknown." Staff may hesitate to record program-critical reasons for

client terminations (ex. poor quality training, lack of day care services, counselor offensiveness, etc.) and prefer the safer lumped categories. This unfairly shields the program from knowledge about clients' real reasons for leaving programs, especially for women clients.

Some occasional follow-up of turned-away applicants could also be useful to the program evaluation. The main question to be asked of this group would be whether the CETA program's referrals provided them the help they needed and what their present life situation is concerning these needs.

3. Conduct exit interviews with all clients. An exit interview should be conducted with all clients as they leave the program as a part of the on-going evaluation system of the program. The schedule of the follow-up is less important than its effort to include all statuses of program exit.

Evaluation, such as through exit interviews or through some more anonymous form of client feedback, should be a built-in part of every CETA program. The focus of all evaluation should be to determine if client needs are being met by the existing programs and services, rather than asking clients to merely give feedback on existing program options with with no opportunity to discuss whether these met their needs or whether these options were even the most effective way of accomplishing what their EDPs required. Women clients need such an opportunity to give evaluative remarks and offer ideas for program improvement which would better serve their own needs and those of other women.

4. Try different approaches to locating clients for follow-up. Locating clients for follow-up contact must be a more intensive effort than an occasional effort to telephone a client during day hours at the

convenience of staff. Often these half-hearted efforts result in staff checking "cannot locate" on client forms. Some experimentation with mailed postcards and clients calling in might be done, as well as efforts made to call in the evenings and weekends when clients are more likely to be at home. Clients without telephones should not simply be dropped from the follow-up pool, which is done at some locations, but an effort made to reach them through their last known employer or other contact number which would be asked for at the time of intake. Clients without a telephone are likely to be the most economically disadvantaged of the client group and their feedback on whether the program made any difference in their lives is critical to include. Follow-up should occur at both a recent point following termination (ex. 30 days) as well as at some later point beyond the usual 90 day interval since it may take longer than 90 days for program skills to be influential in a better job, etc.

Clients should be invited to attend open community input meetings called by the planning council in order to give their ideas to the program. Throughout the follow-up, in whatever form it takes, the staff should demonstrate that it cares about each individual. With this kind of support from the program, clients will hopefully feel freer to give input and feel capable of maintaining economic independence based on skills acquired through their CETA involvement.

5. Provide opportunities for the staff to evaluate the program and one another. Internally, the staff can do much to evaluate its own functioning. Besides having good data on client progress and system effectiveness through the MIS (which should be shared with staff) and an effective system of client folllw-up, staff need to evaluate the program and one another at periodic intervals. Regular staff meetings are a start in this direction, if they include opportunities for individuals to give feedback

to one another in an open and hopefully unthreatening way. If staff feel that individually and collectively they lack certain skills or awarenesses, plans should be made to acquire the missing pieces. Specific technical assistance is available from DOL and can be planned in a form most relevant for that program. Informal arrangements with other prime sponsors, local organizations, or educational institutions to acquire better counseling skills, more supportive service referral capacity, greater awareness of women's needs, etc. could be made either as a purchased course or as an interagency exchange, where CETA would return the favor by providing training in some area of its expertise. Such groups as Better Jobs for Women in Denver are now developing a CETA sponsored courses for staff use in acquiring skills to place more women in non-traditional jobs, which programs may wish to contract for later in FY 77 when they are ready. Other women's organizations could provide such training on a contractual or reciprocal basis. The point is that staff need to recognize through their internal evaluation of the program and each other that one never reaches a point of being "qualified" for all purposes. Rather, the art of facilitating human growth and change requires a constant and ongoing effort to remain current and skilled as a facilitating individual or agency.

G. SUPPORTIVE SERVICES

Recommendations for program planners and operators:
1. Assess the supportive service needs of all clients.
2. Know the community services network and use it.
3. Develop interagency formal financial and non-financial agreements.
4. Use CETA paid supportive services to supplement existing community services.

There is a demonstrated need for supportive services for both the clients interviewed in this research and their assessment of women's needs in their areas in such items as child care, transportation, medical and

and legal services, and mental health and other counseling. In order to satisfy these needs to allow women clients full access to all program activities, training, and employment placement, the following recommendations are offered:

1. Assess the supportive service needs of all clients. As discussed in the intake section, discussion with clients should occur regarding what kinds of personal life circumstances need attention prior to and during their active involvement in the program. The information should be solicited in such a way as to communicate to the client that it is appropriate to share such information and that it will be used to more effectively serve them rather than to screen them in or out of certain program experiences. The supportive service needs and their proposed solutions would be identified and noted in the EDP which would be updated as needed throughout the client's involvement in the program, including the addition of other supportive service needs and their proposed solutions as these might emerge. Acknowledging and responding to women's supportive service needs in this fashion is a major step toward improving the quality of CETA services provided to women.

2. Know the community services network and use it. Once needs are identified, adequate referral to free or affordable services requires that the staff be highly informed about local resources. Staff should be required to have this sort of information for referral and should be required to use it. Administrators should provide regular updating and exposure to new or altered community organizations for staff use in working with clients. Such informed referrals are of use to women and other clients since they can prevent wasted efforts at the wrong agency.

It is important that this staff knowledge not simply be secondarily acquired through written information notebooks, although these are an

important start. Staff need to have visited as many of the organizations as possible in order to share this knowledge with their clients. Program administrators must take a stronger role in requiring this kind of expertise in their staff members and allowing them in-service time to acquire and maintain this knowledge. The proposed community services course (see earlier discussion in this chapter) would assist in this goal. Program administrators can also monitor that EDPs include supportive service needs and that services or referrals are made for each need identified. Again, such directed effort would benefit women clients.

3. Develop interagency formal financial and non-financial agreements. After determining which community service organizations are likely to be those in greatest demand by the program for serving client supportive service needs, formal agreements with these organizations are needed. A specific agreement with Department of Social Services, for instance, for the use of Title XX (Social Security Act) child care funds would allow direct payment or subsidy of child care expenses for low-income CETA women clients needing this service. Equivalent agreements could be made with local clinics to provide pre-work physicals or legally required immunizations required for clients' children to enroll in day care centers. These services, preferably, would be paid out of such clinic's reserve funds for the care of the indigent.

In addition, group rates for bus passes are probably negotiable with public tranportation systems. Free access to school buses, a system used in some rural non-Colorado programs (see appendix for listing of these special programs for women), would be a valuable service for clients who live in areas where there are no public buses. Other contracts for services need to be developed with WIN, Vocational Rehabilitation, and other public

agencies.

When such services are contracted for and pre-arranged, supportive services for women can be provided more efficiently and women will benefit from better quality CETA program involvement.

4. Use CETA paid supportive services to supplement existing community services. If, after thorough knowledge and experience with local organizations, it is concluded that in certain supportive service need areas there is a shortage of quality services available, then some direct application of CETA funds is needed. If no such funds are budgeted, women directly are discriminated against since it is women who so frequently have extensive supportive service needs, especially for child care. Based on the supportive service assessment data entered into the MIS from individual ESPs, planners can assess what the need areas are. Combined with the first level of information and experience with available resources, planning decisions can be made about how much of a need there is and for which kinds of services. Budget determinations can then be made.

If CETA funds are needed to provide supportive services, many approaches are possible. PSE and WE positions can be designed in public and non-profit organizations which provide child care, for instance. These organizations could then be contracted with to provide free or low cost child care for CETA clients' children. Child care OJTs could also be arranged in private for-profit child care centers, especially those run by companies where CETA OJTs are employed, which could serve as a basis for arranging a contract for free or reduced cost child care for CETA clients. Contracts with child care centers that can pick-up and deliver children from their homes save the parents from negotiating public transportation both to take children to and from child care facilities as well as to take themselves to and from work or training.

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Some non-Colorado programs have purchased or leased vans to transport clients and their children to training and day care facilities. This means that parents and children could all arrive at the CETA offices in their own way and then be transported as a group to their other locations. Vans in these programs are also available for clients to use for interviews and application filling out chores during their job development experience.

The problem that many CETA programs have which are trying to be responsive to the supportive service needs of clients, is that funds are used without sufficient knowledge of the level of community services in that need area. This results, sometimes, in programs unnecessarily spending money out of ignorance of their own communities' free or sliding scale services which might more inexpensively serve their clients. Since CETA programs have scarce resources and clients have many supportive service needs, agencies must break down their isolation and learn about one another in order to not spend their scarce funds unwisely.

Determining when to spend CETA funds for supportive services, then, should not simply be a decision based on a well-intentioned staff attempting to serve clients' needs. It should be based on a careful understanding that if CETA does not provide that service, that a client's need will go unfilled. Arrangement of supportive services are central to assuring women equal access and success in CETA programs and should be continued after placement until the woman's first pay check arrives. CETA and community agencies can assure the woman's success by seeing that supportive service needs are met.

H. CETA AND THE DEPARTMENT OF LABOR (DOL)

Recommendations for program planners, operators, and DOL officials:

1. Prime sponsors should run their local programs with a minimum of DOL interference.

2. DOL should end cost per placement as the primary program effectiveness indicator.
3. DOL should encourage prime sponsors to experiment, especially in providing new and improved services to women.
4. DOL should require CETA coordination with other agencies.
5. DOL should monitor action plans of prime sponsors.
6. DOL should reconsider present income criteria for eligibility.
7. DOL should encourage prime sponsors to work together.
8. DOL should abolish veteran's preference for PSE and assure that more economically disadvantaged get PSE positions.
9. DOL should include prime sponsors in the creation of regulations and instructions for CETA.

1. Prime sponsors should run their local programs with a minimum of DOL interference. The spirit of CETA is a decategorization and decentralization of funding and program to the local level. If this is to be fully realized, DOL should have only a minor role in administering local programs and in determining their effectiveness. Local programs should determine local goals. Many CETA instructions at present direct local programs to serve more veterans or migrants or whatever the presently lobbying group is at DOL, rather than allowing local programs to serve whomever they feel is most in need in their local areas. If women concentrate their input at the local level, they will be served without DOL placing more requirements on local programs.

2. DOL should end cost per placement as the primary program effectiveness indicator. DOL places too high an emphasis on placement figures without looking behind these figures to assess the quality of the job placements or the groups of individuals getting the job placements. Since most of the programs in the state have post-program job placement wages averaging less than $3/hour, the issue of quality of job placements needs to be raised, even for programs who have high percentages of clients getting jobs. Programs need the freedom to determine how many people they will serve and how much time and program service each should receive without the pressure of such inappropriate criteria being applied in evaluation efforts. DOL should credit programs which serve the "expensive" clients,

many of whom are women with extensive supportive service needs.

3. DOL should encourage prime sponsors to experiment, especially in providing new and improved services to women. DOL's role in CETA should be to enable local programs to more effectively serve the "unemployed, underemployed, and economically disadvantaged" for which CETA was intended. It should further encourage programs to try out model and experimental approaches rather than carry on with program service mixtures which have been used with limited success for women. Various such programs are in progress around the country (see appendix of programs on women). DOL could assist prime sponsors by disseminating findings and materials from such projects to enable prime sponsors to create their own such projects.

4. DOL should require CETA coordination with other agencies. If DOL intends for CETA and other local organizations to coordinate their efforts, it should facilitate their doing so rather than simply requiring local programs to declare this intention in their program planning documents. If DOL is responsive to local programs who need assistance in accomplishing this, then it should make relevant training available to such programs and/or provide funds for them to hire the kinds of training or services they feel is most valuable from other agencies.

DOL can communicate with other departments of government at the national level to facilitate such local coordination. In particular, DOL could nationally arrange for HEW funds to be made available to local programs for their use in providing supportive services to clients. Such national level efforts would benefit local women in need of supportive services during their CETA program involvement.

5. DOL should monitor affirmative action plans of prime sponsors. DOL has a legal requirement concerning affirmative action stemming from

the assurances and certifications required of each program. DOL can monitor that CETA program staff has read and understand the affirmative action requirements of the law prior to developing means monitoring their implementation. The fact that stereotyping and sex-tracking of women clients through CETA programs occurs is evidence that affirmative action monitoring needs to be stepped up. DOL must require that prime sponsors follow their own affirmative action plans as well as see that contracting subsidized employers also follow affirmative action practices.

Part of the affirmative action effort should be to create an improved grievance procedure which is discussed with all program participants. This procedure would require DOL action following an individual or outside monitoring group's review of local program practices and claim of discriminatory treatment of women. If DOL finds that programs are in non-compliance, DOL should see that CETA funds are withheld until necessary changes occur to remedy the problem. Local women's groups should see that DOL follows the requirements of the law in this affirmative action and grievance procedure process.

6. DOL should reconsider present income criteria for eligibility. Income criteria, while a satisfactory screening criteria for some purposes, often serve to discriminate against women. Women who are displaced homemakers or otherwise newly single are expected to declare the household income level (which would include their former husband's income) whether or not they are sharing in its use or even have access to it at present. Further, for those women who are divorced and have custody of their children, any court assigned alimony to the wife and/or child support income may not be regularly received. It is also

income information which has to be used in the context of their actual economic situation. Questions which determine the actual amount of present income the woman makes or is regularly receiving are the relevant questions for women, not the income level of their household in the previous twelve months. In addition, consideration should be given to women from dual worker households which are low-income, but above the poverty guideline cut-offs, since an increase in these women's earning potential would raise the entire household above poverty.

7. DOL should encourage prime sponsors to work together. Prime sponsors and DOL need to facilitate prime sponsors working together on joint projects and services. A local Denver effort to blend ES and CETA services into a job match program would seem to be such an example of breaking down the isolation of prime sponsor programs. DOL could work with HEW at the national level on programs which local prime sponsors could be involved in at the local level. The many women's projects funded through CETA funds are such examples, and DOL should disseminate the findings of these programs. Without such information sharing, prime sponsors seeking to work together to improve services to women are locally "reinventing the wheel" all across the country, when additional information would assist everyone's efforts to plan and work together.

8. DOL should abolish veteran's preference for PSE and assure that more economically disadvantaged get PSE positions. The present practice under CETA of requiring local programs to give veterans special preference for PSE and other program components is discriminatory toward the economically disadvantaged, and women in particular, since it assumes that veterans are the neediest group in the population when they are not. The present regulations for the newest round of Title VI funds call for a 35% enrollment of Vietnam era veterans, yet this group is not unemployed in any

greater numbers than women (8.6% in December, 1976 as opposed to 8.8% for women workers over 16 years of age according to Women's Washington Representative, 5/77. This same information points out that although women are, for that same month in time, 43% of the unemployed, they were enrolled in only 35% of PSE jobs nationally. Further, women heads-of-household have 50-60% higher unemployment rates than men heads-of-household and are among the most disadvantaged of the workforce's unemployed members. Therefore, such open and discriminatory preference for veterans at the expense of women and other disadvantaged groups is clearly discriminatory and should be ended.

9. DOL should include prime sponsors in the creation of regulations and instructions for CETA. Local programs need to assert themselves more in relationship to DOL. If regulations and instructions are found to be unreasonable, there should be a process for resolution. To head off this problem in the first place, prime sponsors should have greater participation and power in determining what kinds of federal and regional DOL involvement is needed in order for programs to successfully operate. Decentralized programs are not a reality unless the programs share in the decision making regarding the law that enables them to exist.

The main task of DOL, then, is to foster local autonomy under CETA and the capacity of the programs to administer themselves. DOL should also assume an enabling role in assisting programs to recognize women's needs and design programs services to meet them. To accomplish this, DOL should take a supporting rather than directing orientation toward local programs.

CETA is a relatively new law which is in the midst of review prior to its refunding on a more permanent basis. It is, therefore, in a state of review where community and women's group input concerning its

effectiveness is needed both from program operators and from client advocates. Women should learn the law, its local application, and the various community and regional level structures of government which relate to CETA. With this information and their own experiences and perceptions of the needs of women, informed input to these various levels of the CETA system needs to be given in order that CETA can more effectively serve women in the future.

APPENDIX ITEMS

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GLOSSARY

ABE:
Adult basic education; preparatory training before high school equivalency work can begin.

AFDC:
Aid to families with dependent children; category of welfare assistance.

BOS:
Balance of state; the area within the jurisdictation of a state, which is not included in the comprehensive plan of another prime sponsor, and serves as its own prime sponsor.

CETA:
Comprehensive Employment and Training Act of 1973.

Consortium:
Entity formed by an agreement between local units of government to plan and operate a CETA program. Example: the Colorado Springs/El Paso County consortium in Colorado.

DP (Direct Placement):
Participant in CETA program placed in an unsubsidized job during the grant year after only receiving assessment and job referral services from the CETA program.

Discouraged Worker:
One who has actively sought work, but being unable to secure employment has become discouraged and no longer actively seeks a job.

Displaced Homemaker:
Person who is over 35 years of age and has worked in the home providing unpaid household services for family members and has not been gainfully employed; has had or would have difficulty finding employment and/or has depended on governmental assistance as the parent of dependent children; but is no longer eligible for such assistance; and/or has depended on the income of a family member and has lost that income.

Economically Disadvantaged:
Person whose income is at or below poverty level or receives welfare.

Size of family	Nonfarm family	Farm family
1	$2,970	$2,550
2	3,930	3,360
3	4,890	4,170
4	5,850	4,980
5	6,810	5,790
6	7,770	6,600

Employability Development Plan:
Plan incorporating participant's interests, skills, and services to be provided by CETA, agreed to by the participant and CETA staff person, leading to an employment goal.

Employment Service (ES):
Also called Job Service Center; state operated job placement agency.

ESL:
English as a Second Language; instructions in English for those who speak little or no English.

FAR:
Federal Authorized Representative; DOL representative to local CETA programs.

FY:
Fiscal year; October 1 through September 30, in the federal system.

GED:
General Educational Development; or high school equivalency.

Head of Household:
A member of a family who provides more than 50% of the support of one or more other family members.

Indirect Placement (IP):
Participant placed in unsubsidized employment during the grant year after receiving CETA training, employment, or supportive services.

MAC:
Manpower advisory council; also called planning council.

MIS:
The Management Information System used by local Prime Sponsors.

MPC:
Manpower Planning Council; also called advisory council.

Non-positive Termination:
Also called negative termination; end of participation in a CETA program for any reason other than for a placement into unsubsidized work or for participant to enter school or the military or be transferred to another CETA program. Some examples of non-positive terminations: laid off, health, family care, refused to continue, etc.

OE:
Obtained employment; person obtaining unsubsidized employment through other means than by placement by the prime sponsor.

OJT:
On-the-job-training; subsidized training in private sector, with requirement to hire at end of training period.

Participant:
Individual who qualifies and receives services in a CETA program.

Placement:
Hiring of an individual referred by a CETA program into unsubsidized employment by an employer.

Positive Termination:
End of participation in a CETA program for any of the following reasons: placement into an unsubsidized job, participant enters school or military, or participant is transferred to another CETA program.

Prime Sponsor:
Unit of government, combinations of units of government, which have entered into a grant with the Department of Labor to provide CETA services.

PSE:
Public Service Employment; Employment with a private non-profit or public agency, usually of short duration, paid for wholly by CETA funds.

RFP:
Request for Proposal; public announcement inviting interested groups to submit proposals for CETA funding.

SER:
Jobs for Progress; deliverer of CETA services.

Significant Segments:
Those groups of people, to be characterized, if appropriate, by race, ethnic, sex, age, occupational or veteran status which causes them to generally experience unusual difficulty in obtaining employment and who are in need of the service provided by the CETA act.

SUCAP:
Southern Ute Community Action Program; deliverer of CETA services.

Supportive Services:
Services which are designed to contribute to the employability of participants, enhance their employment opportunities, assist them to retain employment, and facilitate their movement into permanent employment not subsidized under the CETA act. Examples are: child care, transportation, medical or legal needs, and personal or mental health counseling.

Transitional Quarter:
Period between July 1, 1976 and October 1, 1976, when federal fiscal year beginning changed. Future federal fiscal years will begin October 1.

Underemployed:
A person working part-time, but seeking full-time work, or is working full time but whose salary relative to family size is at or below poverty level.

VNB:
Virginia Neal Blue Women's Resource Center; a deliverer of CETA services in Colorado.

WE:
Work experience; subsidized short term employment in public or private non-profit agencies to gain on the job experience.

WIN:
Work Incentive Program; for people on AFDC, administered jointly by the Department of Social Services and the State ES.

NOTE: Definitions, where appropriate, were taken from CETA legislation and Colorado laws and bills.

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ADVISORY BOARD MEMBERS

1. Art Albright, Denver--employer representative
2. Toni Alvarado, Denver--client representative
3. Estella Archuleta, Cortez--SER, Ute Mountain Program
4. Judy Carder, Pueblo--CCSW
5. Burt Carlson, Denver--Director, Division of Employment and Training
6. Avis Cloud, Grand Junction--client representative
7. Eleanor Crow, Denver--Office of Civil Rights
8. Edward Dash, Ft. Collins--educator
9. Hap Fay, Denver--employer representative
10. Houston Greene, Ignacio--CETA and ES director
11. Robert Hase, Denver--Colorado Division of Employment and Training
12. Dorothy Hampton, Paonia--employer representative
13. Angeline Heaton, Denver--CCSW
14. Joyce James, Denver--former CETA staff
15. Gini Janes, Denver--former CETA staff
16. Marge Johnson, Denver--CCSW
17. Mary Johnson, Denver--client representative
18. Fern Latino, Pueblo--CCSW
19. Joycelyn Little Chief, Denver--Denver Indian Center
20. Virginia Mondragon, Denver--client representative
21. Edna Mosley, Denver--State Personnel office
22. JoAnn Nation, Denver--ex-offender and educator
23. Marianne Olguin, Denver--client representative
24. Dorianna Ozzello, Denver--Division of Employment and Training
25. Ray Rodriguez, Colorado Springs--CETA director

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26. Pauline Reece, Denver--Denver Income Maintenance Experiment

27. John Romero, Pueblo--CETA director
(Vicky Curry, alternate)

28. Walter Speckman, Greeley--CETA director
(Judy Griego, alternate)

29. Sandra Vieth, Grand Junction--client representative

CHAIRPERSON:
30. Judy Henning, Englewood--CCSW

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Colorado Commission on the Status of Women
RICHARD D. LAMM, Governor
State Services Building • 1525 Sherman, 600C, • Denver, Colorado 80203
TELEPHONE: AREA CODE (303) 892-2821, 2822

LETTER OF CONFIDENTIALITY TO THOSE INTERVIEWED

Thank you for agreeing to participate in this research project, funded through a federal Comprehensive Employment and Training Act (CETA) grant to the Colorado Commission on the Status of Women (CCSW). The CCSW is a state funded agency concerned with studying women's problems and improving the opportunities available to them. It is not connected to the Employment Service, Department of Social Services, or any other agency. The goals of the research are to determine the extent of CETA services being provided to women and whether these services meet women's actual needs. Recommendations will be made for needed improvements based on this information which will hopefully benefit all women and men served by CETA programs.

Interviews will be conducted with CETA client women and men, CETA staff, and employers working closely with CETA programs as part of the research. The interviews are confidential and your name will not appear anywhere in the written report or be used in any way that would identify you. We hope this will encourage you to express your ideas fully.

We appreciate your involvement in this research and the time required for this interview.

Kathleen Blumhagen
Kathleen Blumhagen, Project Director

Bettye N. Cheadle
Bettye Cheadle, Project Assistant Director

Ricki Martinez
Ricki Martinez, Project Research Assistant

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PRIME SPONSOR INFORMATIONAL SURVEY

1. Names and locations of CETA funded programs and/or projects under your jurisdiction.

2. Staff at all locations. Give job title and demographic data on each employee. (race, ethnic/cultural heritage, sex, age, etc.)

3. Names and locations of other programs in which your prime sponsor is involved which relate to CETA activities.

4. Budget for each and all programs. (see items 1 and 3) Indicate source of funding if other than CETA.

5. Check which date elements are maintained on clients as a part of your present informational system.

	Sex	Age	Ethnic/ Race	Educational Level	Occupational Category Preference
a. client contacts all categories	___	___	_____	_____	_____
b. Clients referred to you from other sources	___	___	_____	_____	_____
c. clients counseled/ advised	___	___	_____	_____	_____
d. clients tested or evaluated	___	___	_____	_____	_____
e. clients placed in institutional training programs	___	___	_____	_____	_____
f. clients placed in OJT positions	___	___	_____	_____	_____
g. clients placed in PSE positions	___	___	_____	_____	_____
h. clients placed in work experience	___	___	_____	_____	_____

	Sex	Age	Ethnic/ Race	Educational Level	Occupational Category Preference
i. clients placed in unsubsidized jobs	___	___	_____	_____	_____
j. clients placed in other activities	___	___	_____	_____	_____
Explain:					
k. clients followed up	___	___	_____	_____	_____

6. Tests now in use for client evaluation (General Aptitude Test Battery, etc.)

7. Names and affiliations of members on Prime Sponsor's Manpower Planning Council.

8. Comprehensive Manpower Plan now in use. (Attach either complete copy or narrative portion thereof).

9. If applicable, contracts used for subcontracted training and other client services. (Attach sample).

10. Describe other types of data maintained which are not included above.

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KB__ BC__ RM__
M__ F__
B__ C__ A__ I__ O__
Approx. Age___
Date_____

PRIME SPONSOR STAFF INTERVIEW SCHEDULE

Instructions: Use as open ended questions; code responses or add notes as needed.

1. Describe a model for clients' entry and experience in the program. (probe: outreach, intake, counseling, testing, training, education, placement, follow-up)

2. Explain the CETA planning process for your area. (probe: effectiveness, do women have input, community input)

3. How are general needs of clients identified in your area? (probe: political, current studies, DOL statistics)

4. What do you see as the needs of women clients in your area? (probe: child care, transportation, job exploration, Displaced Homemaker)

5. Is your program meeting these needs? What needs to be done?

6. Do you have an internal system for evaluating the effectiveness of of your program? Describe it. How useful is it?

7. Describe the relationship between your program and DOL.
(probe: helpful, hindrance, unclear)

8. How useful are the evaluation processes of DOL in assessing the effectiveness of your programs?

9. What do you feel is strong about your present program? Why?
(probe: outreach, counseling, evaluation, training, subsidized jobs, placement, follow-up, administration, Advisory Council, political officials, etc,)

10. What do you feel needs improvement about your present program? Why?
(probe: same as #1)

11. Comments and reactions concerning CETA, the law and its effectiveness. What changes are needed and where are these changes indicated?

Date:

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Supportive Services Survey - prime sponsor staff

Obtain copy of any Referral books in use. Obtain breakdown of supportive services budget.
When appropriate, add following questions to staff interview as information on their referral system.

1. If clients have child care needs, what help is available locally?

2. If clients have transportation needs, what help is available locally?

3. If clients have medical or dental needs, what help is available locally?

4. If clients have mental health or personal counseling needs, what help is available locally?

5. If clients have legal needs, what help is available locally?

KB_____ BC_____ RM_____

A____B____C____I____O____ M____ F____

EMPLOYER INTERVIEW SCHEDULE -275- Age_____ Date_____

Code or add notes as needed.

1. What is your relationship with ____ program?
   _____Advisory Council member
   _____Location for PSE slots #positions_____# women _____
   _____Location for WE slots
   _____Location for OJT slots Titles of positions:
   _____Location for unsub. jobs

   Comments:

2. How did you become involved with ____program? How long have you been involved?
   _____Own interest, initiative, etc.
   _____By invitation of prime sponsor or though their ads
   _____Through pressure by local groups, agencies, political officials, etc.

   Comments:

3. What kind of agreement or contract, including the amount of money involved, do you have with ____ program? (Obtain copy of contract if possible. Determine remuneration per participant and services to be provided by employer.)

   Comments:

4. How are the positions in your company/business defined in terms of responsibilities of both the participant and your company/business?
   _____PS gives extensive directions
   _____We work jointly with PS to define positions and terms
   _____We do most of the defining and deciding

   Details of positions:

5. How are participants selected for your location?
   _____I don't know; PS handles all of the arrangements
   _____We work jointly with PS in selecting people
   _____We select our own people from those PS sends over

   Comments on process of selection:

6. What do you see as the needs of CETA clients affecting their training and employment?
   _____ABE or GED
   _____ESL
   _____Skills training
   _____Employment history problems
   _____Communication and interpersonal skills
   _____cultural differences
   _____supportive services needs: (child care, transportation, medical, etc.)

   Comments:

7. What do you see as the needs of CETA client <u>women</u> specifically which affect their training and employment?
   _____ABE or GED
   _____ESL
   _____Skills training
   _____Employment history problems
   _____Communication and interpersonal skills
   _____cultural differences
   _____supportive services needs: (child care, transportation, medical, etc.)

   Comments:

8. Are these needs of clients being met? How and by whom? How can this be improved? (probe: PS and own involvement in problem and possible solutions)

9. How can more women become involved in your positions?
_____Prime Sponsor should take steps to locate more women
_____We should take the initiative and recruit more women
_____We are not interested in having more women because _____

Comments:

10. Do you have an Affirmative Action Plan? Describe it. (Obtain copy if possible.)

11. How have the participants in your company/business done?
_____No success. Problems:

_____Some success.

_____Success. Reasons:

Comments:

12. Have you hired any of the participants? Why? (or why not?) How many?

13. From your experience with _____program, how would you evaluate their effectiveness in assisting clients with training and employment needs? (probe for reasons and specifics)
_____I don't know enough to evaluate
_____From limited knowledge, seems good
_____From limited knowledge, seems poor

How can this be improved? Comments:

14. How can the business community become more involved in working with the employment and training needs of your area?
_____We're not interested in becoming extensively involved.
_____We'd like to help, but don't know how or where.

Specific ideas:

15. Is your company/business interested in expanding your involvement with CETA related programs? How?

16. Do you have other ideas about programs working with training and employment which have not been covered?

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KB_____ BC_____ RM_____
A_____ B_____ C_____ I_____ O_____
M_____ F_____
Date_____

CLIENT INTERVIEW SCHEDULE

Code or add notes as needed.

1. How did you learn about ____ program? (Probe: agency referral?)
_____Another agency referred me. Which:
_____Media, pamphlets, posters
_____Friend told me
_____Prime Sponsor outreach worker

Comments:

2. Why did you go to _____ program? (Probe: more than one reason?)
_____Wanted a job
_____Wanted a sponsor for training costs
_____Wanted job counseling, aptitude evaluation, etc.
_____Required to come by WIN, Probation, etc.

Comments:

3. What happened when you first came to the office of ____ program? (Use numbers)
What happened the next visit? And the next, etc.? Duration & time interval between

_____filled out application and/or was interviewed to determine eligibility _____
_____received information about all of ____programs. _____
_____talked with a counselor about my job plans, training needs, goals, etc. _____
_____took written tests for job aptitude. State which: _____
_____was referred to a job listing or micro-fiche _____
_____was placed in one of these
PSE_____ WE_____ OJT_____ Duration:_____
Salary_____ Paid by PS?
Position title_____
_____was signed up for courses in _____ at a school named _____ _____
_____was placed in a job.
Job title_____ Salary_____ _____
_____was sent to ES or elsewhere _____

Comments:

Client Interview, page 2 -280-

Select which of the following questions apply to the individual.

4. What did you think of the written application?
_____Reasonable; asked for necessary information
_____Unreasonable; asked for irrelevant or overly personal information
Examples:
_____Form was confusing or unclear; difficult to complete
_____Asked for information I didn't have with me
Examples: (social security #, income, proof of citizenship)

How could it be improved?

5. What was the introduction to the various programs and services of _____ program like? How was the information given?
_____Complete; helped me choose
_____Incomplete, confusing, patronizing, or otherwise poor

How could it be improved?

6. What was the counseling like? Did you talk about the various jobs that you might do? (Clarify quanity and quality)
_____helpful; counselor was resourceful, supportive, etc.
_____not so helpful; counselor directed me, treated me poorly
_____received individual counseling
_____received group counseling

How could this be improved?

7. How did you feel about the aptitude tests?
_____positive; tests were meaningful, helpful when interpreted, etc.
_____negative; tests was meaningless and results were not interpreted well

How could this be improved?

8. How was the decision made for WE/OJT/PSE/training? Was this what you wanted?
_____I decided with the counselor's providing needed information
_____Counselor decided; I had little to do with the decision
_____Decision based largely on scheduling or availability problems of desired experience?

How can this be improved?

Client Interview, page 3

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9. What did you know about the WE/OJT/PSE/training before you started it?
_____complete description with written contract or other printed agreement
_____incomplete description; didn't really know what I was getting into

How can this be improved?

10. Did you complete the WE/OJT/PSE/training?
_____Yes
_____No

Discussion of reasons:

11. What did you think of the WE/OJT/PSE/training?
_____learned, earned, etc. as needed and desired
_____poor experience.

Discussion of reasons:

How can this be improved?

(Follow-up questions for terminated clients)
12. Have you found a job since your involvement in _____ program?
_____Yes. Job title_____ Salary_____
Is this the job you were trained for?
_____No; still looking
_____No; not interested in working now. Reasons:

Discussion:

If no, move to Needs Assessment Interview

13. (If yes) How did you get the job?
_____Prime sponsor's program referred me
_____ES referral
_____own efforts or connections

Discussion:

Go to Needs Assessment Interview

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NB____ BC____ NM____
A____ B____ C____ I____ O____
M____ F____ Age____
Date____

NEEDS ASSESSMENT
INTERVIEW SCHEDULE

Instructions: Use as open ended questions. Code response or add notes as needed.

1. What is your present (or last) job? Was it full or part-time? If last job, when did you leave it? What did it pay? What is the best job you ever had? What did it pay?

2. How did you feel about the present (or last) job? What problems were there?
_____ Salary inadequate. Amount, if given:
_____ Working conditions poor (dangerous, dirty, demeaning, etc.)
_____ Benefits, vacations, etc. inadequate.
_____ Explain:
_____ Intrinsic: work unsatisfying, below one's ability, etc.
_____ Hours: too long, not enough, irregular work schedule, etc.
_____ Transportation and distance from home
_____ Home problems: husband
_____ Home problems: children
_____ Medical, legal, etc. problems preventing work
_____ Traditional/non-traditional issues.

Comments:

Needs Assessment, page 2

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3. What kind of job would you really like to have and think you could do?
_____I would really rather not work. Proposed means of support:
_____I have no idea
_____Salary level desired for adequate style of life:
_____Desired benefits:
_____Desired working conditions:
_____Intrinsic: aspects of work itself desired:
_____Hours, seasons (ex. school year and hours):
_____Distance from home; transportation:
_____Traditional/non-traditional issues.

Comments:

4. What would it take to get you into that ideal job and keep you there?
_____ESL (English as a second language), ABE (Adult Basic Education), and/or GED
_____Vocational or skill training
_____Supportive Services (possibly limit to same ones as Activity 2)
_____Child Care. Age of children:
_____Counseling and support (confidence, assertion training, career planning, etc.)
_____Medical (ex. diet rehab.)
_____Legal
_____Economic, financial planning help
_____Changes in household with spouse, children, etc. Specify:
_____Creative work situation (Flexitime, shared job, 4 day work week, etc.)
_____Stable economy, political enviornment, etc. to assure that job will exist in the future.

Needs Assessment, page 3

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5. Do you have other employment needs not covered above?

6. What do you see as employment needs of other women in this area?

CETA PROGRAMS FOR WOMEN ACROSS THE COUNTRY

Information was provided from the following sources:

- Women's Bureau, Department of Labor, Washington, D.C.
- Employment and Training Administration, Department of Labor at the national and regional level
- Manpower Coordinator's Office, Department of Health, Education, and Welfare, Region VIII
- National Association for Commissions on the Status of Women

Abbreviations:

- NAOP - National Apprenticeship Outreach Program
- NPSPS - National Program for Selected Populations
- NRDP - National Research and Demonstration Projects
- NUL - National Urban League
- RTP - Recruitment and Training Program, Inc.

Information is mainly shown for Title III programs. A few programs in other titles are listed, although local Title I programs for women are generally not shown. The listing is as complete as information that was available on that program.

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ALABAMA

Montgomery Consortium, $241,821 (NPSPS)
"Employment Assistance to the Displaced Homemaker" will offer special assistance to 120 economically disadvantaged displaced homemakers (older than 22 years and of any present marital status, including unmarried mothers) for securing non-traditional jobs. Program includes 3-4 weeks of counseling and job orientation in a Career Development Center followed by OJT, work experience, or classroom training. Link Foundation is the sub-contractor. Contact George Poston, 10 High Street, Suite 320, Montgomery, Alabama 36104, 205-288-2906.

ARIZONA

Phoenix's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

CALIFORNIA

Advocates for Women is funded in part through a Title I grant from Alameda County CETA. The program, located at several locations, includes both women in apprenticeships and women in management components and is funded through both CETA and outside sources. The program has also received Governor's 4% funding in the past to conduct a study to identify barriers to non-traditional jobs for women. Contact Velma Parness, Advocates for Women, 236 Sutton, San Francisco, California 94108.

Alameda County uses its Title I funds to fund part of the Advocates for Women program.

Alameda County uses Title I funds for a "Voucher System for Non-traditional Jobs" program.

California State Council of Urban League has received a Governor's 4% grant to place 250 women in subsidized jobs as a result of training.

City of Glendale uses Title I funds for a "Women's Career Development Center."

City of Los Angeles uses Title I funds for a "Career Planning Center, Inc."

City of Los Angeles uses its Title I funds to operate a "Chicana Service Action Center."

City of Los Angeles has a Title I funded program directed toward women offenders contracted to Volunteers of America.

Los Angeles' NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

Los Angeles RTP, Inc. has a Title III (NRDP) grant to conduct a "Minority Women's Employment Program."

Marin County, $32,625 (NPSPS)
"Pre-Vocational Experience Program" will provide a 3-6 week pre-vocational program on non-traditional jobs to 130 women prior to their entry to the regular Title I program. The program will develop a network with private sector employers for participants to spend a day learning about various types of occupations. Women's Way is the sub-contractor. Contact Myra Terziev, Marin County CETA, 21 Tamal Vista Blvd., Suite 115, Corte Madera, California 94925, 415-453-4490.

Merced County, $202,781 (NPSPS)
"New Career Opportunities Project" is designed to serve disadvantaged women in a rural agricultural area. 36 women will receive stipends while participating in a personal support program, career counseling, and educational training. The women will select and negotiate their own OJT's in such areas as water/wastewater treatment plant operation, animal heath technician, dairy assistant, claims representative, landscape design, etc. 3 weeks of intensive personal support counseling precedes the OJT experience. Contact Eddy Tate, NCO Director, 2222 "M" Street, Merced, California 95340, 209-726-7324.

New Ways to Work has received a Governor's 4% grant to develop placement opportunities for women and older workers and handicapped in non-traditional, education-oriented, and service jobs.

Orange County uses its Title I funds to operate a "Mature Women Program."

Sacramento/Yolo Consortium uses its Title I funds to operate a "Jobs Resource Center."

Sacramento/Yolo Consortium uses its Title I funds to operate a "Womanpower" program directed toward women offenders.

San Francisco uses its Title I funds to fund part of the Advocates for Women program.

Santa Clara/San Jose Consortium uses its Title I funds to operate a "Coalicion de Boricua, Inc."

Santa Clara Valley Employment and Training Board, $230,310, NPSPS
"Project Esperanza" (Hope) will provide residential services and classroom training in electronics to 40 ex-offender women and those recently incarcerated. Supportive services will include transportation, emergency food, housing, legal assistance with custody of children concerns, medical services, and others services as needed through the use of a voucher system. 40 of the women and their children will be housed together in a cooperative housing setting which will include a cooperative day care center and common kitchen. Economic and Social Opportunities, Inc. is the sub-contractor. Contact Arlene Speidel, Santa Clara Valley Employment and Training Board, 675 N. 1st St., Suite 412, Santa Clara, California, 408-277-4000 ext. 4277.

Stockton/San Joaquin Consortium uses Title III (NPSPS) funds to operate a "Project Step," focused on female heads-of-households.

Tulare/Kings Consortium, $175,527 (NPSPS)
"Job Training for Rural Women Program" will provide employment services to 50 disadvantaged women. Services will include a 13 week WE in mostly non-traditional job areas as well as 1 day a week of classroom training entitled "Seminar in Career Development." The program planners assume that rural farm working women are good candidates for non-traditional jobs.

COLORADO

Boulder County, $165,000 (NPSPS)
"Reapplication of Skills for Women Project" will serve 150 women with traditional employment skills (ex. secretarial) in order to upgrade them to management training positions through WE and OJT. Extensive supportive services are provided and participants exposed to community supportive service resources. Weekly support group sessions are held for participants. Program is operated jointly with the Boulder County Women's Resource Center. Contact Clair Largesse, CETA Program, 2750 Spruce St., Boulder, Colorado 80302, 303-447-9675.

Colorado Springs's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

Denver Better Jobs for Women, $100,000 (Office of National Programs) provides services leading to placement of women in skilled trades and crafts as unsubsidized OJTs or apprentices. Supportive services and community information referral are provided. Contact Sandy Carruthers, BJW, 1545 Tremont, Denver, Colorado 80202, 303-893-3534.

DELAWARE

City of Wilmington, $150,000 (NPSPS)
"Employment, Training, and Counseling Program in Non-Traditional Jobs Program" will provide job-seeking skill classes and job training to 95 women for heavy industrial employment in such occupations as shipfitting. Contact Carol Weeks, Division of Manpower Development, 1314 Market St., Wilmington, Delaware 19801, 302-571-4285.

DISTRICT OF COLUMBIA

Washington, D.C., Governor's Special Grant for a CETA program project on "Working Opportunities for Women."

FLORIDA

Brevard County, $199,991 (NPSPS)
"Work Opportunities for Women" program will facilitate the integration of 280 economically disadvantaged women in non-traditional jobs. One component of the program will provide machinist training to the handicapped. Willway Company and Brevard Community College are the sub-contractors. Brevard Community College is in its third year of CETA funding on WENDI (Women's Educational Development Incentive) program under Title I and has added the NPSPS funds for its WOW (Work Opportunities for Women) program. Both programs have basic core curricula and specialized support counseling for women. Contact Lee Metcalf, Manpower Planning Staff, Brevard County, 2575 N. Courtney Blvd., Merritt Island, Florida 32952 or Muriel Kay Elledge, Brevard Community College Continuing Education for Women, Cocoa, Florida 32922, 305-452-9480.

Broward Consortium, $300,000 (NPSPS)
"Freedom of Career Choice Program" includes a research design comparing enrollees in this program with others in the CETA system. A voucher system will be used under which 50 women will develop their own jobs in non-traditional areas. After a week long orientation seminar, the women will contract their own 6 month PSE, OJT, or classroom training experiences. Vouchers are available for the costs of child care and other supportive service needs as well. Contact Jeanette Overgard, WFCC Coordinator, c/o Broward County Manpower Council, 650 N. Andrews Avenue, Fort Lauderdale, Florida 33302, 305-765-4545.

Jacksonville's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

State of Florida has a Governor's 4% grant to operate an "Employment Assistance to the Displaced Homemaker" program.

State of Florida has a Governor's 4% grant to operate a "Career Development for the Long-Termed Unemployed" program in Gainesville.

Tampa's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

GEORGIA

Atlanta's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

Atlanta, RTP, Inc. has a Title III National Research and Demonstration Project on "Minority Women Employment."

Commission on the Status of Women has completed a Governor's 4% CETA funded study focusing on issues confronting women in the state in the area of industrial health services, obstacles to full employment for women, and special problems of women offenders. The Commission is now involved in working with existing agencies to provide services determined through the study to be in need.

ILLINOIS

Champaign County Consortium has been awarded a Title I grant for a "Women's Employment Counseling Center"

Chicago NUL has a Title III (NAOP) grant for a "Labor Education Advancement Program."

Peoria NUL has a Title III (NAOP) grant for a "Labor Education Advancement Program."

INDIANA

Fort Wayne Consortium, $195,902 (NPSPS)
"Displaced Homemaker Project" will serve 102 women with an intensive counseling, orientation, and job development program.

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City of Hammond, $198,078 (NPSPS)
"Non-Traditional Jobs: An Achievement Motivation Program for Women" will offer an intensive psychology-oriented program for non-traditional jobs using McClelland's Theory of Achievement Motivation. Twenty groups of women (10 per group) will attend 2 weeks of training followed by additional training and job development through the labor unions. Child care and tranportation are provided. Northwest Indiana Women's Bureau is the sub-contractor. Contact Dani Hart, NW IWB, 7 Elizabeth, Hammond, Indiana 46320, 219-931-1095.

The Indiana Laborer's Training Trust Fund completed a Governor 4% grant program to train 100 women as construction laborers.

Indiana School of Business has just completed a program to assist the state manpower planners to establish program guidelines concerning the integration of women and minorities into favorable employment circumstances within the Indiana labor market.

Purdue University completed a Governor 4% grant funded study of Labor Market Indicators to develop a system of local labor market indicators which relate to the conditions of supply and demand of female workers in the Multi-County Manpower Planning area of Indiana.

The Women's Career Center, Inc. received a Governor 4% grant in FY 76 to provide services to increase the employability of women who have been unemployed for at least one month.

IOWA

Black Hawk County, $100,000 (NPSPS)
"Manpower Services for Women Offenders Project" will provide work experience, OJT, classroom training, and support services for 40-50 adjudicated women referred by courts and social agencies. Contact Dick Shaw, KWWL Bldg., 3rd floor, East 4th and Franklin Streets, Waterloo, Iowa 50703, 319-291-2546.

KENTUCKY

Louisville-Jefferson County Consortium, $288,761 (NPSPS)
"YWCA Creative Employment Project" will provide OJT and vocational education to 469 women in the area of non-traditional jobs, including job development for these jobs. Contact Bitsy Jacobus, CEP, 608 S. 3rd St., Louisville, Kentucky 40202, 502-585-5550.

MARYLAND

Maryland Commission for Women's Economics Committee was awarded CETA funds to monitor counseling and training programs of local ES offices. Committee is conducting a series of sex role sensitization sessions for ES counselors.

Governor's 4% Grant to Baltimore CETA program was awarded for a "Baltimore New Directions for Women" program.

Baltimore NUL, Title III (NAOP) for a "Labor Education Advancement Program" which focuses on women.

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MASSACHUSETTS

City of Boston, $393,449 (NPSPS)
"Non-Traditional Occupations Project" will provide education in vocational alternatives and skill training in maintenance mechanics to 100 disadvantaged women with an emphasis on minorities. Project is sub-contracted to the Boston YWCA. Contact Vivan Gilfoyle, Project Director, Boston Manpower Administration, 5 Doane Street, Boston, Massachusetts 02109, 607-878-5942.

Governor's 4% Grant, $40,000
"Wider Opportunities for Women," a non-profit private agency providing supportive counseling and career guidance for women of all ages. WOW also provides job development experience in recognizing and fulfilling the needs of employers with regard to AA goals.

MICHIGAN

City of Detroit has a Title I grant to sponsor a "New Options Personnel, Inc." program for women.

Flint NUL has a Title III (NAOP) grant to sponsor a "Labor Education Advancement Program" for women.

Lansing Consortium, $195,828 (NPSPS)
"Female Heads of Household and Welfare Recipients Training Project" will serve 380 women in assessment, career exploration, employability planning, and OJT or classroom training in mostly non-traditional jobs with local skill shortages. Ingham Intermediate School District Career Center and Lansing Community College are the sub-contractors. Contact Mike Dennis, Lansing Tri-County Regional Manpower Administration, 1850 W. Mount Hope, Lansing, Michigan 49010, 517-487-0106.

Muskegon Consortium has funds from Titles I and II for a special program at the "Every Woman's Place, Inc."

Ottawa County has Title I funds to sponsor a local Women's Resource Center's CETA program for women.

Saginaw County, $107,918 (NPSPS)
"Meaningful Supportive Services to Women Project" will provide counseling and workshops for 180 women to participate in career awareness for non-traditional jobs or better-paying accessible jobs. Chyrsallis Center of Saginaw Valley State College is the sub-contractor. Contact Dennis Brieske, Manpower Administration, Saginaw County Courthouse, Saginaw, Michigan 48602, 517-793-4561.

MINNESOTA

State of Minnesota, $136,061 (NPSPS)
"Non-Traditional Employment for Women Project" (NEW) will provide upgrading OJT and classroom training to 96 women (either economically disadvantaged or below median family income for the area) for non-traditional job training and job development. Supportive services are provided. Contact Calvin Finch, Governor's Manpower Office, 690 American Center Bldg., 160 E. Kellogg Blvd., St. Paul, Minnesota 55101, 612-296-6050.

Minneapolis has a Title III (NAOP) grant to fund a "Labor Education Advancement Program."

Ramsey County (during FY 76) had a Governor's 4% grant to conduct a "Working Opportunities for Women" project. The project provided supportive services as well as specialized counseling, information, and referral for women in a five county metropolitan area with special information and encouragement given to women for non-traditional jobs. Contact Lois Snook, Working Opportunities for Women, 2353 Rice St., St. Paul, Minnesota 55113, 612-484-3317.

St. Paul NUL has a Title III (NAOP) grant to fund a "Labor Education Advancement Program."

MISSOURI

City of Independence, $76,047 (NPSPS)
"Women Employable - Displaced Homemakers Project" will set up 6 satellite centers to provide skill training, supportive services, and resource information to 236 heads-of-household displaced homemakers. Sub-contractor is the Women's Resource Bureau of the University of Missouri. Contact Bob Rosen, 103 West Kansas, Independence, Missouri 64050, 806-836-8666.

Kansas City's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

St. Louis's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

NEW HAMPSHIRE

Hillsborough County has aTitle III (NPSPS) grant to operate a "Non-traditional Employment and Training Opportunities" program targeted at rural women.

NEW JERSEY

Bergen County, $396,183 (NPSPS)
"Women's Resource Center Project" will implement a job resource center to serve 600 women in employment activites (ex. assertiveness training, job referral, etc.). 120 of group will receive direct vouchers to negotiate their own OJT in non-traditional jobs as well as arrange for child care, classroom training, and other needs. Contact Kenneth Ryan, Bergen CAP - Employment Program, 90 Main Street, Hackensack, New Jersey 07601, 201-342-3512.

Middlesex County, $180,312 (NPSPS)
"Career Advancement Program" will provide a management training and internship program to 40 women in order to improve their potential to secure higher income jobs. Rutgers University is the sub-contractor. Contact Beverly Webster, Middlesex County CETA Program, 85 Bayard Street, Room 202, New Brunswick, NJ 08901, 201-246-6919.

Monmouth County, $202,670 (NPSPS)
"Program of Non-Traditional Jobs for Women" will train 110 women in appliance, auto, and parts sales. Program includes classroom training, vocational assessment and counseling, self-awareness and assertiveness training, and job development in coordination with local CETA Title I program. Clients do own job development through a job club. Women's Center at Brookdale Community College jointly operates program. Contact through CETA Program, Court Street School, Freehold, NJ 07728, 201-431-7000.

NEW HAMPSHIRE

Hillsborough County, $202,608 (NPSPS)
"Non-Traditional Employment and Training Opportunities Project" is designed to provide 70 head-of-household women with private sector OJT in non-traditional jobs. The project will serve urban and rural areas. Contact Kathy Humphrey, Millsborough Human Development Administration, P.O. Box 416, Manchester, NH 03105, 603-669-0709.

NEW YORK

City of Buffalo, Title I grant to CETA program for a "Heads of Household" program focused on women.

New York City, Title I grant to CETA program for a "Lady Carpenter and All-Craft Institute"

Onondaga County has a Title III (NPSPS) grant to operate a "Job Readiness and Basic Life Skills Program for Women Offenders" program.

Westchester/Putnam Consortium, $400,000 (NPSPS)
"Women's Career Resource Center/Non-Traditional Jobs Project" is a two pronged project to help women familiarize themselves to the process of finding jobs. 100 women will be placed in PSE, skill training, and OJT in non-traditional areas. Contact Keith Drake, Manpower Director, County Office Bldg., White Plains, NY 10601, 914-682-2222.

NORTH CAROLINA

Raleigh has a Title VI grant to conduct a program directed toward rural women, "Madison County, North Carolina Council on Appalachian Women."

OHIO

Akron's NUL received a Title III (NAOP) grant to fund a "Labor Education Advancement Program."

Cincinnati - RTP, Inc. received a Title III (NRDP) to fund a "Minority Women's Employment Program."

Ohio Task Force for the Implementation of the Equal Rights Amendment received (FY 76) a Governor's 4% grant to implement the Equal Rights Amendment and to examine state statutes and regulations for compliance by the Governor and Attorney General.
Women's Resource and Policy Development Center was funded through a Governor's 4% grant to provide outreach, training, and apprenticeship placement for currently unemployed or underemployed young women in the skilled craft occupations. Other objectives included research on barriers to employment for women in these fields. FY 76.

OKLAHOMA

Tulsa's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

OREGON

Portland's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

RHODE ISLAND

Providence CETA Program, Women's Educational Equity Act funds ($75,000) to study a CETA program, the local Opportunities Industrialization Center (OIC). The study is to identify constraining factors to women in curricula, operations, and administration of the OIC vocational preparatory program and to create strategies and materials to combat these. Contact Patricia O'Connor, WEEA Program, OIC of RI, 45 Hamilton St., Providence, RI 02907.

State of Rhode Island, Governor's 4% Grant
A project, now completed, was funded to provide women with the skills necessary to conduct a successful job search. The focus was on hunting techniques, resume writing, informational and employer interviewing.

SOUTH CAROLINA

Columbia's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

SOUTH DAKOTA

State of South Dakota, $100,000 (NPSPS)
"Non-Traditional Employment Training Project" will focus on employers and labor organization officials to provide apprenticeship training for 60 women in the metropolitan Sioux Falls area. Part of the program will consist of a media campaign to promote non-traditional jobs for women. Contact Polly Penny, Office of Manpower Programs, Capitol Lake Plaza, Pierre, South Dakota 57501, 605-224-3101.

TENNESSEE

Governor's 4% Grant has been awarded to the Knoxville Women's Center.

Governor's 4% Grant has been awarded to the Memphis Women and Girls Employment Service.

Memphis/Shelby Consortium, $300,000 (NPSPS)
"Preparing for Non-Traditional Jobs Project" will assist 100 women to obtain the necessary skills to move into non-traditional jobs through such activities as motor skill training. OIC, WAGES, and the Girls' Club are the sub-contractors. Contact Lethia Thomas, Human Services Division, City Hall, Room 420, Memphis, Tennessee 38103, 901-525-5550, ext. 257.

State of Tennessee has a Governor's 4% grant to operate a "Transitional Center for Women."

TEXAS

Dallas RTP, Inc. has a Title III (NRDP) grant to operate a "Minority Women's Employment Program."

Houston RTP, Inc. has a Title III (NRDP) grant to operate a "Minority Women's Employment Program,"

Texas Panhandle Manpower Consortium, $322,482 (NPSPS)
"Female Heads of Household Program" will train 200 disadvantaged displaced homemakers in heavy equipment maintenance and equipment operation in a primarily rural 18 county area. The program includes extensive supportive services, classroom training, and OJT. Texas Panhandle Community Action Program is the sub-contractor. Contact Jim Wood, c/o Panhandle Regional Planning Commission, P.O. Box 9257, Amarillo, Texas 79105, 806-372-3381.

VIRGINIA

Fairfax County, $300,000 (NPSPS)
"Women in Non-Traditional Jobs Program" will internship, OJT, and classroom train 100 women in 7 targeted non-traditional vocational areas (with $4-5/hour beginning wages) in such jobs as television technology, moving and storage, and office machine and appliance repair. Program includes public information campaign to promote acceptance of women in non-traditional jobs. Results will be "packaged" for distribution upon request. Contact Michael Gilbert; 4057 Chain Bridge Road, Suite 301, Law Building, Fairfax, Virginia 22203, 703-691-2762.

Governor's 4% Grant, "Step Up" program for women in Richmond, Norfolk, Arlington, and Roanoke areas.

WASHINGTON

State of Washington has a Governor's 4% grant to operate a "Non-traditional Job Opportunities" program in Longview.

State of Washington has a Governor's 4% grant to operate a "Working Options for Women" program in Olympia.

Tacoma's NUL has a Title III (NAOP) grant to operate a "Labor Education Advancement Program."

WISCONSIN

Madison has received as Title III, Office of National Programs grant to operate a "Women's Apprenticeship Aid Center."

Marathon County, $77,400 (NPSPS)
"Women's Employment Opportunity Program" will operate a Title I type program for 150 women, 70% of whom will be disadvantaged. Program will include an experimental project for child care with variable work schedules, job pairing, job sharing, flexitime, etc. Special emphasis is on re-renty women's placement into non-traditional jobs through information dissemination in the community to end attitudinal barriers to women's non-traditional employment. Wisconsin University Extension is the sub-contractor. Contact Marge Jones, WEOP, Marathon County Courthouse, Wausau, Wisconsin 54401, 715-845-6231.

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Racine's NUL has received a Title III, NAOP grant to operate a "Labor Education Advancement Program."

State of Wisconsin Governor's 4% grant has funded a "Skilled Jobs for Women" project.

Waukesha Consortium, $75,620 (NPSPS)
"Training Program for Women" is designed as a two-part project for 24 disadvantaged, head-of-household women. Six weeks of classroom training will include pre-employment orientation and technical training in shop, industrial math, etc. OJT in such jobs as turret lathe operator and engine lathe operator will follow with $4.20/hour or more in salary in positions which have insurance and other fringe benefits as well as an opportunity for upward mobility. Child care will be provided for those needing it. Contact Mary Sue Short, WOW CET Consortium, Waukesha County Courthouse, 515 West Moreland Blvd., Waukesha, Wisconsin 53186, 414-544-8046.

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CETA READING

Baker, Joe, Institutional Training as a Social Investment: An Evaluation. Salt Lake City, State of Utah Office of Labor and Training, 1331 South State, Suite 300, Salt Lake City, Utah 84115. October, 1975.

Chicana Rights Project, Mexican-American Legal Defense and Education Fund, Position Paper Prepared in Conjunction with a Formal Allegation Filed With the ARMP, USDOL Charging Sex Discrimination by the City of San Antonio. San Antonio, MALDEF, 501 Petroleum Commerce Bldg., 201 North St. Mary's Street,Texas 78208. Fall, 1976.

Consad Research Corporation, Consad Career Development Package, Contract of the U.S. Office of Education, HEW. Available from Consad Research Corporation, 121 N. Highland Ave., Pittsburgh, PA 15206, 1976.

Gewirtz, Paul and Steinberg, James, How to Monitor Federally Funded PSE Programs. Available from the Center for Law and Social Policy, 1751 N Street N.W., Washington, D.C. 20036. August, 1975.

Manpower Administration, USDOL, Manpower Research and Development Projects, U.S. Government Printing Office, Washington D.C., 1976. 0-594-759.

National Commission for Manpower Policy, Manpower Program Coordination, Special Report #2, October, 1975. Available from NCMP, 1522 K Street N.W., Suite 300, Washington, D.C. 20005.

Office of Manpower, Office of Human Development, DHEW, HEW Manpower Programs: A Guide to Program Linkage, Fall, 1976. Available from regional HEW offices.

Salazar, Anita, Colorado Employment and Training Review, Denver, State Board for Community Colleges and Occupational Education. Available from SBCCOE, 1525 Sherman, Denver 80203. January, 1976.

Sexton, Patricia Cayo, Women and Work, 1976. Available through the USDOL.

Torpey, William G., Federal Personpower Involvement, 1977. Available from author at 810 Grand View Drive, Alexandria, VA 22305.

USDOL, The Comprehensive Employment and Training Act of 1973: Questions and Answers, Washington, U.S. Government Printing Office, 1974. 0-536-424.

USDOL, Dual Careers, Washington, U.S. Government Printing Office, 1975.

USDOL, Employment Standards Administration,Women's Bureau, and the Employment and Training Administration, A Guide to Seeking Funds from CETA: A Booklet to Assist Individuals and Organizations to Learn How to Apply for CETA Monies, Washington, U.S. Government Printing Office, 1976. 905-542.

USDOL, ETA of Region VIII, CETA Assessment, Review, and Evaluation System Manual. No date. Available from Regional Office.

USDOL and USDHEW, Manpower Report of the President, Including Reports by the USDOL and the USDHEW, Washington, U.S. Government Printing Office, April, 1975. (date of transmittal to Congress)

In addition to these general sources, the actual CETA law itself (Public Law 93-203), its regulations, and its regional instructions to program operators should be studied. All are available from the regional office of the Employment and Training Administration, USDOL.

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SUPPORTIVE SERVICES INFORMATION

Auer, Marilyn A. and Shaw, Constance B., Colorado Women's Resource Book, 1976. Available from 607 S. Clarkson, Denver 80209.

Better Jobs for Women, Community Resources, 1977. Available from BJW, 1545 Tremont Place, Denver 80202.

Boulder County Women's Resource Center, Directory of Services for Women (for Boulder and Denver areas). Available from BCWRC, 2750 Spruce Street, Boulder 80302.

Child and Youth Centered Information System Project, Colorado Department of Social Services, Colorado Directory of Services for Children, 1976. Available from CDSS, 1575 Sherman, Denver 80203.

Community Planning and Research Council, Directory of Community Services of the Pike's Peak Region, 1976. Available from CPRC, 25 East San Rafael, Colorado Springs 80903.

Information Resources Interest Group of the Council on Human Resources, Directory of the Human Service Agencies of Mesa County, Grand Junction, 1976. Printed as a community service and available through Mesa College of Grand Junction.

Larimer-Weld Regional Council of Governments, Larimer County Human Resources Directory, 1975. Available from Larimer-Weld COG, 201 E. 4th Street, Room 201, Loveland 80537.

Mile High United Way, Inc., Community Services in Metropolitan Denver, 1974 edition. 1977 edition will be available after June, 1977 from MHUW, 1375 Delaware, Denver 80204.

Volunteer and Information Center of Boulder County, Boulder County Community Resources Directory, 1976. Available from the Center, 2305 Canyon Blvd., Suite 201, Boulder 80302.

Women's Center, A Directory of Services for Women (metropolitan Denver area), 1977. Available from the Women's Center, Community College of Denver, Red Rocks Campus, 12600 West 6th Ave., Golden 80401.

Exhibit No. 12

STATEMENT

OF

DAVID T. DUNCAN

ACTING REGIONAL ADMINISTRATOR

REGION VIII EMPLOYMENT AND TRAINING ADMINISTRATION

BEFORE

COMMISSION ON CIVIL RIGHTS

ON

THE AGE DISCRIMINATION ACT OF 1975

JULY 29, 1977

DENVER, COLORADO

Mr. Chairperson Dr. Fleming, Commissioner Freeman, other testifiers, distinguished guests, Commission staff, I am honored to have been requested to share with you my reactions to the questions you wish to pose dealing with the Age Discrimination Act of 1975. I must state that my answers to your questions are mine and may or may not be consistent with the policies of the Employment and Training Administration (ETA), U.S. Department of Labor. ETA policy is best enunciated by the Assistant Secretary of Labor for ETA, the Undersecretary of Labor and/or the Secretary of Labor.

It is my understanding through discussion with commission staff that these hearings are for the purpose of obtaining opinions on what constitutes unreasonable discrimination on the basis of age in programs or activities receiving federal financial assistance. I am further advised that the programs receiving federal assistance which resulted in my being asked to testify are the Comprehensive Employment and Training Act programs, specifically those covered by Titles I, II and VI of the Act.

A second and equally important aspect of these hearings is to solicit opinion regarding procedures that might be worthy of implementing to insure and enforce compliance with the provisions and intent of the Age Discrimination

Act of 1975. As you know, the Comprehensive Employment and Training Act (CETA) is a complex piece of legislation which attempts to address the problems of unemployment in our Country through an employment and training system. It was signed into law on December 28, 1973, was designed to provide "job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons" to enable them to secure self-sustaining, unsubsidized employment. Unlike the Federally-administered program efforts of the preceding 12 years, however, CETA offers a flexible, decentralized system of comprehensive and decategorized training and employment programs, planned and operated by States and local units of government, subject to Federal agency oversight. The Act (as amended) contains the following seven titles:

--Title I of CETA creates a decentralized program structure, placing the authority to plan and operate a flexible system of manpower services, including training, employment, counseling, testing, and placement, in the hands of prime sponsors. For the most part, the latter are States and units of local government in jurisdictions of 100,000 or more population.

--Title II authorizes a program of developmental transitional public service employment for areas of "substantial unemployment" (defined as areas having 6.5% or more unemployment) to be administered in the same decentralized manner as programs carried out under Title I.

--Title III authorizes the Secretary of Labor to provide additional employment and training services to such special groups as Indians, migrant and seasonal farmworkers, ex-offenders, youth, and others, whom the Secretary determines to have particular disadvantages in the labor market. This title also provides for research, demonstration, and evaluation programs to be administered by the Secretary.

--Title IV contains continuing authority for the Job Corps, originally authorized under Title I-A of the Economic Opportunity Act of 1964.

--Title V establishes a National Commission for Manpower Policy to serve as an independent policy advisory group with responsibility for examining manpower questions and suggesting to the Secretary of Labor and the Congress particular means of dealing with them.

--Title VI (created by the Emergency Jobs and Unemployment Assistance Act of 1974) provides for a large temporary program of emergency public service employment specially designed to help ease the impact of the high unemployment generated by the economic downturn in 1974-75.

CETA was the result of over 12 years of national involvement in developing and operating programs that offered a variety of training, employment, and related services designed to help unemployed and underemployed persons, particularly the disadvantaged, secure and retain unsubsidized employment. The predecessors of CETA--the Area Redevelopment Act (ARA) of 1961, the Manpower Development and Training Act (MDTA) of 1962, the Economic Opportunity Act (EOA) of 1964, and the Emergency Employment Act (EEA) of 1971--provided specialized, nationally-determined programs for target groups identified in the legislation (e.g., those person experiencing structural unemployment, youth, minorities, older workers, and the economically disadvantaged). The proliferation of these efforts, which were administered by separate and often competing sponsors, produced a series of frequently overlapping and seldom coordinated program approaches and target-group priorities.

Growing dissatisfaction with this extensive fragmentation and complexity resulted in the passage of CETA, which incorporates the following basic concepts:

--First, the principal responsibility for the planning and operation of programs under CETA is decentralized and moved from federal control to that of State and local-elected officials designated as prime sponsors. This important change reflects the underlying assumption that local government officials, who are closer and more immediately accountable to the people requiring employment and training services, can best plan programs and set priorities geared to the needs of their particular areas.

--Second, local program funding is consolidated and coordinated. The previous network of direct Department of Labor contracts with many diverse local sponsoring organizations, without any effective overall management for the local areas as a whole, has been largely replaced by a system of block grants to the chief elected officials at the State and local government levels, who are responsible for planning and managing the total program. These officials, because of their sensitivity to local conditions, have the capacity

to minimize duplication and overlap and achieve greater coordination with other employment and training resources in the community.

--Third, decategorized funding under CETA encourages localized, flexible responses to current or anticipated manpower needs. The individual prime sponsor may develop the full range of activities permitted under predecessor legislation--including classroom training, on-the-job training, work experience, public service employment, and such manpower and supportive services as counseling, direct placement, and child care--or may restrict the spectrum of program offerings in order to intensify services in response to local requirements.

The three broad target groups to be served under CETA--the unemployed, the underemployed, and the disadvantaged--were previously identified under MDTA (unemployed and underemployed), EOA (unemployed or having low income), and EEA (unemployed and underemployed). Under the previously referenced legislation, the Federal government established priorities among these target groups and also mandated various levels of service for other special groups (e.g., veterans). Under CETA, prime sponsors, rather than the Federal government, can now decide which activities will be available for which broad and special target groups within the framework of local needs, changing local labor market conditions, and the requirements of the Act.

Generally, prime sponsors are units of State and local government that are responsible for operating CETA employment and training programs to serve the needs of their communities. Prime sponsors are generally one of the following: States; cities or counties with populations of at least 100,000; or combinations of units of government, called consortia, in which at least one member jurisdiction has a population of 100,000 or more.

Prime sponsors are responsible for determining local needs and providing programs designed to meet them through such activities as classroom training, on-the-job training, work experience, public service employment, counseling, testing, job development, child care, and other supportive services. Sponsors can arrange to provide these services directly or through contracts or subgrants with such organizations as the State Employment Service, vocational education agencies, community groups, or private firms. They are responsible for monitoring and evaluating programs to ensure that they meet local needs.

Titles I, II and VI of CETA, are based on the assumption that elected officials at the State and local level are more attuned to the needs of their communities than are Federal

officials and are therefore better equipped to oversee the planning, development, and operation of employment and training programs in their jurisdictions. In addition to their roles as the grantees or responsible officials for a variety of other State or Federal programs, these officials are directly accountable through the electoral process, to the people of the community.

The legislation, in providing funds to those chief elected officials, allows them the responsibility for determining the appropriate program mixes, operational costs, and to a limited degree, clients to be served. The Department of Labor has the responsibility to advise prime sponsors on appropriate alternatives to proposed courses of action, and assumptions to consider that may not have surfaced during the prime sponsor planning process, as they attempt to maximize program effectiveness and efficiency. The Department also has the responsibility to supervise, validate and evaluate prime sponsor program performance.

This Federal oversight role as undertaken by the Department of Labor is based upon the legislative compromise position developed during the passage of CETA in 1973. On the basis of the Act itself, the committee reports, and the floor debates, the legislative intent

regarding Federal oversight can be summarized as follows: First, while there should be a strong and active Federal role at all stages of planning, review, and implementation, the Secretary of Labor should not attempt to "second guess" the good-faith judgment of the prime sponsor in developing and implementing a program to meet the needs of the sponsor's jurisdiction. Second, the Federal government should not intrude in the day-to-day operations or decision-making process of the prime sponsor. Third, the Secretary of Labor may not rely on certification alone to ensure that Federal funds are expended in accordance with the law, but must exercise independent judgment. The Secretary is expected to look behind the sponsors' certifications of compliance, primarily through a process of regular auditing, spot checking, and follow-up on complaints of interested parties.

The four most significant elements of the Federal role, therefore, are: establishing national objectives, priorities, and performance standards; providing technical assistnace; reviewing and approving plans; and assessing and evaluating performance.

In addressing the first issue that this hearing is designed to seek comment about; namely, what constitutes unreasonable discrimination on the basis of age, it appears to me you are asking for a definition of what could be construed to constitute equity of access into the CETA program. Related to this and a major by product of the program is,

what constitutes equitable service. With equity of access and service defined, unreasonable discrimination would be defined as a significant deviation from this equity. In my judgment, program (CETA) access and service equity determinations could involve using as an information base for planning purposes a number of data sources. Demographers and statisticians for example might support the use of census data, public health projections, U.S. Department of Commerce data sources, work force projections, labor force turnover data, current population surveys, etc. Any one of these data sources might be desirable for any number of Federal programs that your instructions have stated an interest in. For CETA, however, one data base stands above all others in my judgment.

The data base to which I refer is the Employment Security Automated Reporting System (ESARS) unemployment and applicant seeking work data base. This unemployment insurance (UI) data base with recent legislative changes covers almost the entire unemployed work force as a result of the provisions of the base UI program, the extended benefits program (EB), the federal supplemental benefits program (FSB) the Supplemental Unemployment Assistance program (SUA), Unemployed Claims of Federal Employees (UCFE) program and the unemployed claims of ex-service persons program.

When unemployment insurance tables are combined with the applicant data files of the employment service, we have almost a complete listing of the unemployed people in a state, a county, possibly a city, an SMSA and in this country. This ESARS data base is continually updated monthly and includes those persons who are most in need of assistance. To determine equity of access, therefore, one needs to decide on the data base to use to describe the universe (or population) in terms of specific program characteristics including age and then attempt to insure that program entry is so structured that the program participation profile mirrors the universe of need profile. Only by structuring program intake for significant segments can a lack of deviation from equity result. ESARS has a number of tables which might be used to collect this unemployment data, however, the ones which are probably the best source for determining the reasonableness or unreasonableness of the provision of service to persons over 40 years of age would be tables 08, 22, 22a, and 22b. Attached for your information are copies of these ESARS tables.

As you can see from these print-outs there are up to six different age breakouts along with many other demographic characteristics. These, in my judgment, would be very adequate and very relevant to determination of the universe of need of people able to benefit from CETA employment

and training services according to age. Once a community profile can be developed, the next step in insuring a minimal deviation from equitable entry into a CETA program funded by Title I, II or VI would require a potential enrollee or program applicant summary report by characteristic. The existing Quarterly Summary of clientCharacteristics (QSCC) format could be used to compare applicants with participants, and applicants and participants with the universe (ESARS #8 re: age). The QSCC presently compares participants, terminations and placements so with possibly very small modification, a closed loop record keeping system could exist to include the universe characteristics, the applicant characteristics, the participant characteristics, the terminee characteristics and the placement characteristics.

A second major ingredient for insuring that unreasonable discrimination on the basis of age does not occur is the establishment of a management-monitoring system that is actually used. While the previous material related to the planning and base data compilation process, this portion of my discussion will address the importance of the scheduling and sequencing of program management reports.

The present CETA reporting system is tied to a quarterly sequence for program results information. Reports are due to be completed 30 days after the end of the report

quarter. This means that program management data as opposed to fiscal management data is in part four months old when submitted to the regional office. This is too much of a time lapse to insure that compliance with federal intent occurs. A mandatory monthly reporting cycle of the QSCC and QPR data should be instituted on the four groups mentioned earlier, i.e., applicant, participant, terminee and placements. The UI data is already available on a monthly basis in ESARS. As with most management reports, it is desirable that they be viewed and reviewed by more than one person to insure that they are used for the purposes they were designed.

In addition to the report frequency and report elements, another important element in successfully implementing not only the provisions of the Age Discrimination Act but much of the Civil Rights compliance legislation is the report format. Present report formats imply that people are characterized by single characters rather than multiple characters. We have a tendency to batch compile our statistics so we count one person as a female, as between 19 - 21, as a high school graduate, as being an AFDC recipient, as being Hispanic, as having limited Spanish speaking ability, as being handicapped, as being a Vietnam veteran, as being a handicapped/veteran, as being a prison offender, as being unemployed and as being a UI claimant.

We have counted this one person 12 separate times. This makes our data difficult to interpret. We in Region VIII have developed a more reasonable format (copy attached). You may recognize that PEER developed by ETA and Justice Department personnel is similar to the format I am proposing. This type of matrix description keyed on ethnicity and sex better enables us to see people in their true light with multiple characteristics. I have attempted thus far to suggest how one might define what constitutes unreasonableness and how its existence can continually be monitored. In my judgment, we would need a more specifically directed planning process, slight changes in the frequency and data cells in the management reporting system, and continual follow-up. The present CETA planning and reporting procedures do not in my judgment adequately allow for this. Although this is the case, we do attempt to monitor to the best of our ability, the degree to which equity of access and equity of service to significant segment groups access in Region VIII. We first require of our service deliverers an EEO affirmative action plan which describes how affirmative action staffing and affirmative action service to clients will occur regarding significant segment population groups. Approval of this plan is a requirement of finding approval and release. We provide extensive training on how to plan, the elements of the plan, the purpose of the plan and the outputs or results of the plan.

We also provide on-site technical assistance to our service deliverers when we observe variances in their performance that questions the degree of equity they are providing. Last but by no means least, we monitor and evaluate the degree to which it appears they are providing equitable and appropriate service.

In assessing the adequacy of CETA prime sponsors service to the older worker, we have compared program performance between two data bases because of the lack of an adequate CETA data base at this time.

By comparing total applicants against total placements from the ESARS-UI-Table 8 print-out, we can determine the universe of need to job placement ratio. By then comparing this with the participant to placement ratio in the CETA program we can estimate the equity of service provided to persons over 45. Using Colorado data for illustrative purposes, 15.8% of the male applicants in the ESARS applicant file are classifiable as older workers. When older worker placements of males are compared with total male placements we find that 13.8% are placed resulting in a minus 2.2 male older worker applicant to older worker applicant placement differential. Using the same methodology for females, the differential was minus 2.1 thereby showing that there is little difference in differential

between male and female older worker applicant to placement comparisons.

When I look at the comparison between applicants and placements by title in the CETA program in the region using the same methodology, I receive a +.6 for Title I, -1.7 for Title II and +3.5 for Title VI. This leads me to believe that in Region VIII older workers appear to be receiving equitable service. While there are a number of assumptions tied to this type of analysis, I share it with you to let you know that while the present CETA reporting system is not conducive to measuring equity of service, trends toward this end are possible.

In conclusion, let me summarize my thoughts regarding the issues you wished discussed.

First, unreasonable discrimination related to the Age Discrimination Act in the CETA Title I, II and VI programs might be suggested when the applicants desiring to participate in these programs, the program participants, the program positive terminees or the program placements show a significant under-representation when compared with the older worker representation occurring for the particular jurisdiction in the total applicant column on the ESARS Table 8 print-out. Significant under representation could be defined as 15% or greater and be consistent with significant deviation instructions already provided to

prime sponsors with regard to other program performance assessment.

Secondly, participant or client characteristics report summaries need to be required on at least a monthly basis and could benefit from a vastly improved format.

Thirdly, continual monitoring and evaluation by ETA will be necessary.

Again, thank you for giving me this opportunity to share with you these thoughts and recommendations. I firmly believe that they have relevance not only for the manner in which the Age Discrimination Act is implemented but also, the degree to which we effectively implement other pieces of legislation which purport to insure that minorities, women, the handicapped, veterans, youth, the poor and disadvantaged, migrants and seasonal farm workers and other special applicant groups receive equity of access to human services programs and equity of service.

I will be happy to try and answer any questions you may wish to raise. Thank you for your attention.

David T. Duncan

DAVID T. DUNCAN
Acting Regional Administrator

Attachments

TABLE 08
UNEMPLOYMENT INSURANCE CLAIMANTS
BY CHARACTERISTIC AND SERVICES PROVIDED

	Characteristics	Total Applicants	Avail. U.I. Claimant Applicants	Applicants Placed				Referred to Job	Enrolled in Training	Counseled	Placed in Inac. File		
				Total	Over 3 Days	Over 150 Days	3 Days or less				Pos. Terminal Serv.	With Some Serv.	No Service
A	B	C	D	E	F	G	H	I	J	K	L	M	N
08010	Male	010C	010D	010E	010F	010G	010H	010I	010J	010K	010L	010M	010N
08015	Age												
08020	Under 22												
08025	22-39												
08030	40-44												
08035	45-54												
08040	55-64												
08045	65 and over												
08050	Ethnic Group												
08055	White												
08060	Black												
08065	American Indian												
08070	Other												
08075	NA												
08080	Spanish American												
08085	Employment Status												
08090	Full Time												
08095	Part Time												
08100	Not Working												
08005	Job Attachment												
08010	Female												
08015	Age												
08020	Under 22												
08025	22-39												
08030	40-44												
08035	45-54												
08040	55-64												
08045	65 and over												
08050	Ethnic Group												
08055	White												
08060	Black												
08065	American Indian												
08070	Other												

Time period:
Monthly, year to date

TABLE 08 (Con't)
UNEMPLOYMENT INSURANCE CLAIMANTS
BY CHARACTERISTIC AND SERVICES PROVIDED

	Characteristics	Total Applicants	Avail. U.I. Applicants	Total	Applicants Placed			Referred to Job	Enroll in Training	Counseled	Placed in Inac. File With		
					Over 3 days	Over 150 days	3 days or less				Pos. Terminal Serv.	Some Serv.	No Serv.
A	B	C	D	E	F	G	H	I	J	K	L	M	N
08175	INA												
08180	Spanish American												
08185	Employment Status												
08190	Full Time												
08195	Part Time												
08200	Not Working												
08205	Job Attachment												

Report No. MA 5-50

TABLE 22, 22A
Activity Related to the Plan of Service and Balanced Placement Formula

Activity	Total	Female	Age		Veteran			Minority	Economically Disadvantaged	Rural	Migrant	Handicapped	UI Claimant
			Under 22	45 and over	Total	Vietnam Era	Handicapped						
Individuals:	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Applicants Available	010C	010D	010E	010F	010G	010H	010I	010J	010K	010L	010M	010N	010O
Other Welfare	015C												
Attached to a Job	020C												
Seasonal Farmworkers	025C												
Migrants	030C												
Migrant Food Proc. Workers	035C												
Carry-In	040C												
New App. & Renewals	045C												
Partial Registrations	050C												
Other Welfare	055C												
Attached to a Job	060C								Table:				
Seasonal Farmworkers	065C												
Migrants	070C								22 - ES Grant Activity				
Migrant Food Proc. Workers	075C								22A - All Activity				
Counseling	080C												
Testing	085C												
Aptitude Testing	090C												
Perform. & Selection Testing	095C												
Enrollment in Training	100C												
Individuals Placed	105C												
3 Days or Less	110C												
4-150 Days	115C												
Over 3 Days	120C												
Over 150 Days	125C												
Nonagricultural	130C												
Over 3 days	132C												

Report No. MA 5-69,A

TABLE 22, 22A (Continued)
Activity Related to the Plan of Service and Balanced Placement Formula

Activity	Total	Female	Age		Veteran			Minority	Economically Disadvantaged	Rural	Migrants	Handicapped	UI Claimant
			Under 22	45 and Over	Total	Vietnam Era	Handicapped						
Agricultural	135C	135D	135E	135F	135G	135H	135I	135J	135K	135L	135M	135N	135O
After Counseling	140C												
After Aptitude Tests	145C												
After Performance & Selec.	150C												
Seasonal Farmworkers	155C												
Migrants	160C												
Migrant Food Proc. Wkrs.	165C												
Other Welfare	170C												
Attached to a Job	175C												
Wages:	XX	XX	XX	X XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Under $2.10	180C												
$2.10-$2.49	185C												
$2.50-$3.49	190C												
$3.50 and over	195C												
Transactions:	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Total Placements	200C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Placements (exclud. mass)	205C												
Nonagricultural	210C												
Over 3 Days	215C												
Agricultural	220C												
Over 3 Days	225C												
Mass Placements	230C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Nonagricultural	235C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Agricultural	240C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Job Openings Rec'd.	245C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Nonagricultural	250C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
3 Days or less	255C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
4-150 Days	260C		XX	XX	XX	XX	XX	XX	XX	XX	XX	XX	XX
Over 150 Days	265C		XX	XX	XX	XX	XX	XX	XX	XX	X XX	XX	XX

Table 22B

Attachment 3

Plan of Service - Percent Accomplishment and Productivity
ES Grant

Characteristics of Applicants/Activity	New Applications and Renewals			Individuals Placed			Ratio (Percent)	
	Plan	Actual	Percent Accomplish.	Plan	Actual	Percent Accomplish.	Planned Service to New Appls. & Renewals	Actual Service to New Appls. & Renewals
B	C	D	E	F	G	H	I	J
Total	010C	010D	010E	010F	010G	010H	010I	010J
Veterans	015C							
Handicapped	020C							
Vietnam-era	025C							
UI Claimant	030C							
Minority	035C							
Econ. Disadvantaged	040C				Time Period:	Monthly;	Year-to-Date	
Seasonal Farmworkers	045C							
Migrants	050C							
Women	055C							
Older Workers	060C							
Youth	065C							
Handicapped	070C							
				Productivity/Staffyear				
	Plan	Actual	Percent Accomplish.	Budgeted	Estimated			
Individuals Counseled	080C					XXXXX	XXXXX	XXXXX
Individuals Placed	085C					XXXXX	XXXXX	XXXXX
Nonagricultural	090C					XXXXX	XXXXX	XXXXX
Regular	095C					XXXXX	XXXXX	XXXXX
Agricultural	100C			XXX	XXX	XXXXX	XXXXX	XXXXX
Placement Transactions	105C					XXXXX	XXXXX	XXXXX
Nonagri. (excl. Mass)	110C					XXXXX	XXXXX	XXXXX
Regular	115C					XXXXX	XXXXX	XXXXX
Agri. (excl. Mass)	120C			XXX	XXX	XXXXX	XXXXX	XXXXX
Mass Placements	125C			XXX	XXX	XXXXX	XXXXX	XXXXX
Budgeted Staff Years	126C	XXX	XXX	XXX	XXX	XXXXX	XXXXX	XXXXX
Estimated Staff Years Worked	127C	XXX	XXX	XXX	XXX	XXXXX	XXXXX	XXXXX
Job Openings	Received	Filled	Percent					
Total	130C			XXX	XXX	XXXXX	XXXXX	XXXXX
Nonagricultural	135C			XXX	XXX	XXXXX	XXXXX	XXXXX
$3.50 or more	140C			XXX	XXX	XXXXX	XXXXX	XXXXX

REPORT ON AGE DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

CETA TITLES I, II and VI

Report Contents

* Regulations regarding Age
* Placement Data by Age
* Targeting of Age Groups for Title I by Manpower Advisory Council
* Programs and Projects Funded by DMA
  - Older Workers Program - Title I
  - Liggins Tower Project - Title VI
  - Seniors! Inc. Project - Title VI
* Appendix

Denver Manpower Administration

Lupita Gusman

July 29, 1977

REGULATIONS REGARDING AGE

Federal

No mention is made of age requirements on Federal Regulations concerning Titles I, II or VI.

Assurances and Certification section is provided all Title VI Special Project Operators, and states that:

> "No person with responsibilities in the operation of any program under the Act will discriminate with respect to any program participant or any application for participation in such program because of race, creed, color, national origin, sex, age, political affiliation, or beliefs (section 703 (1) and (712)."

Career Service Authority

Most Regular Titles II and VI (Sustaining Level) jobs are located in city agencies and are therefore bound by Career Service Rules. CSA Rules relating to age requirements state:

> RULE 5-16a
>
> "An eligible [for employment list] who is less than sixteen years of age shall not be employed until he has obtained the required age and school certificate".
>
> RULE 10-60
>
> "An employee who reaches the age of 68 shall retire on the last day of the month in which is or her sixty-eighth birthday occurs."

PLACEMENT DATA BY AGE FOR FY 1977*

TITLE I AGE GROUP	TOTAL TERMINATIONS	TOTAL EMPLOYED	% OF TERM. BY AGE GROUP	% OF TOTAL TERMINATIONS
16-21	919	501	55%	22%
22 - 44	1219	796	65%	35%
45+	118	83	70%	4%
	2256	1380		61%
TITLE II				
16 - 21	128	15	12%	3%
22 - 44	288	53	18%	12%
45 +	31	10	32%	2%
	447	78		17%
TITLE VI				
16 - 21	19	9	47%	7%
22 - 44	107	23	21%	19%
45+	7	2	29%	2%
	133	34		26%

* 10/1/76 - 5/31/77

TARGETING OF AGE GROUPS FOR TITLE I

BY MANPOWER ADVISORY COUNCIL

The Community Needs Subcommittee of the Manpower Advisory Council was charged with the responsibility of identifying potentially eligible participants for manpower services. Recognizing that services needs often exceed available resources, this group's task became one of determinining which of all potentially eligible participants would be target groups in Denver.

For FY 1976 priorities were set based on three characteristics: economic disadvantage, ethnicity and age. For FY 1977 a more detailed analysis was used to identify the target groups. Characteristics examined for each of the groups included:

- Percent of population
- Percent of labor force
- Unemployment rate
- Percent of group in poverty
- Mean income
- Percent of applicants at E.S.

Through the application of a series of weighted factors, based on subjective decisions as to relative importance, indexes of need were developed for specific groups in order to arrive at level-of-service goals for the groups identified. The specific methodology used is described in some detail in Appendix I.

The following table shows, for each of the age groups, the FY 1976 plan, FY 1976 actual (through June), the FY 1977 plan, and the FY 1977 actual figures (through May). These data indicate that there is no significant underrepresentation of any group at this time.

AGE GROUP	FY 1976 PLAN	FY 1976 ACTUAL	FY 1977 PLAN	FY 1977 ACTUAL
16 - 21 years	40%	42%	40%	39.4%
22 - 44 years	55%	55%	52%	53.3%
45+ years	5%	3%	8%	7.2%

AGE CHARACTERISTICS OF PARTICIPANTS IN TITLES II AND VI

With the exception of Veterans, no other significant segments have been identified as target groups for Titles II and VI. The following is a breakdown by age of participants in these titles for FY 1977 (through May).

AGE GROUP	% in Title II	% in Title VI
16 - 21 years	22%	21.8%
22 - 44 years	70.5%	70.5%
45+ years	7.5%	7.5%

I. Older Workers Program

This program was funded as a result of a determination ~~by~~ that the employment related needs of older workers (45 years of age and over) were not being addressed. Out of a total of 1506 Title I clients served, only 2% were in that age catagory. The following dual contracts were funded to run concurrently and operated by Corporate Resources, Ltd., a Colorado professional recruiting and executive search corporation:

A. Job Program

1. Program design included counseling and direct placement of 45 - 65 age group.

2. Total Budget was $110,000 funded through 4% Governors Discretionary funds.

3. Program length: 8/8/76 - 5/31/77.

4. Project objectives were:

   a. Increase the number of placements of Older Workers residing in the City and County of Denver.

   b. To foster employer receptivity to Older Workers through direct contact with DMA staff.

   c. To develop linkages with service agencies providing services to the elderly.

   d. To use funds as seed funds in order to have long range system impact.

   e. To provide DMA staff with training in older worker employability development.

5. Project goals were:

   a. To service 380 participants and to make 100 placements.

   b. Of placements, 70% will be at 2.75 to 3.49 per hourly wage and 30% at 3.50 and above (contract modified January 1, 1977 to include these conditions).

B. Intake Module

1. Program design included outreach, intake of older workers into DMA Title I services.

2. Total Budget was $13,000, funded through RFP process with DMA Title I funds.

3. Program length: 1/1/77 - 5/31/77.

4. Objectives were:

   a. Through outpost locations in community centers, recruitment of older workers.

   b. Public relations measures were used to increase awareness of services available to older workers.

   c. A training manual would be developed to be used by DMA staff for use in servicing older workers.

5. Program goals:

   Placement of 98 people.

C. Results

Older Workers Program

Overall Goals

	GOAL	ACTUAL	% OF GOAL
Placements	160	201	126%
% of Retention	75%	68%	90%
Entry Wage			
1. $2.75 to $3.49	70%	31%	44%
2. $3.50 and up	30%	30%	100%

INTAKE MODULE

Placement Goal	Actual Placements	% of Goal
98	98	100%

D. What was learned?

1. A Training Manual is being developed and should be complete by 9/77 to train DMA staff in effectively servicing older workers.

2. DMA must provide an on-going recruitment effort in areas largly populated by potential older workers.

3. A concentrated effort must be made by DMA to educate the Employer Community in hiring of the older worker.

4. All of the above findings will be included in the DMA FY78 plan.

II. Liggens Tower, sponsored by NEDCO For The Elderly Inc.

A Title VI LIFE project funded for 12 months, in the amount of $30,192, for 4 participants.

Project objective is to landscape part of the property and provide labor for elderly residents in planting gardens. Participants will also provide labor to help in redecoration and making draperies and wall hangings for the residents of Liggins Tower.

III. Seniors! Inc.

A Title VI LIFE project funded for 6 months in the amount of $28,914, for 8 participants.

This project provides the following services:

1. Senior volunteers for city projects.

2. A Handy Service to make emergency repairs to seniors whose residences are in need of emergency repair.

3. Supervision and support for Senior participants in the Denver Mayors Neighborhood Garden Project.

4. Will attempt to contact and enlist merchants in their Seniors Discount Program where merchant give discounts to senior citizens.

APPENDIX I

The Process Used to Determine Client Group Priorities

In considering which groups of people the Denver Manpower Administration (DMA) should serve, one overriding fact which had to be faced was that there are many more people who might need manpower services than the DMA can possibly serve. In 1970, there were almost 12,000 families and almost 24,000 unrelated individuals living in poverty in Denver. In 1976, there are about 20,000 people unemployed in Denver, according to the State Division of Employment. In Fiscal Year 1976, the DMA planned to enroll about 2,400 people and it appears likely that there will be less funds available for FY 1977. Given that all those who might need services cannot be served, the MAC sought a way to develop a hierarchy of need so that those population groups which had the highest concentration of need would receive a proportionately larger share of the services. Also, by specifically defining which groups would be served, the DMA would be able to tailor its system more directly to the needs of those people.

To develop these group priorities, the Community Needs Subcommittee of the Manpower Advisory Council (MAC) decided to use a matrix approach in which population groups would be compared using an array of economic indicators related to manpower needs. The committee felt this approach would enable it to make maximum use of hard objective data which was available and, at the same time, enable it to isolate and recognize the points at which subjective value-based decisions had to be made.

The broad population characteristics considered were ethnic group, age, sex, veteran status, and head of family status. Five economic indicators were selected as being important measures of the groups' relative manpower needs. They were: percent of the population; percent of the labor force; unemployment rate; percent of the group in poverty, all of which were derived from census figures; and, percent of applicants at Employment Service in 1974. The committee initially included a mean income figure also, but since this was only available on a statewide level, it was left out in deriving the economic index of need. A matrix was created (See Table "E") in which the population groups were cross listed by the economic indicators and the values were filled in. To create a relative index of need for the population groups, it was necessary to combine, in some way, the information from each of the five economic indicators. This was done in two steps. First, to obtain a common standard, the figure which indicated the greatest need for manpower services in each of the five columns was set at 100 and the other values were scaled down from these. The second step was one which called for considerable subjective judgement on the part of the committee. The members felt that not all the economic indicators were equally indicative of manpower need. Thus, the committee assigned a weighting factor on a scale from 1 to 10 to each of the economic indicators and multiplied each of the indicators by its respective weight. Finally, the resulting values for each population group were summed to obtain a relative index of need. (See Table "F") Later these indices for broad groups would be cross-tabled to give indices of need for more specific population groups.

Appendix I
Continued

In the second stage, a frequency distribution matrix was set-up which showed the percentage of each ethnic-sex group which fell into the veteran, age group, and head of family categories (See Table "G"). This information would be used as an indication of the relative frequency of the specific groups when the Table "F" indices were cross tabbed. As in the first series of matrices these figures were then set to a standard and weighted. Subjective decisions were again made. The committee felt that by serving heads of families, the DMA could achieve more widespread benefits than by serving people without dependents. It therefore weighted the head of family category at one and a half times the categories of veteran and age group. Overall, the committee felt the frequency distribution was not as important a component as the economic index of need in determining manpower needs and therefore weighted the frequency index at only half the index of economic need. The results are seen in Table "H".

The committee then combined the economic index of need and the frequency index, (See Table "I") and from this produced relative indices of manpower need for 64 specific population groups -- defined by ethnic, sex, age, veteran, and head of family status (See Table "J"). The groups were ranked in order of need and the committee decided to use the twenty-five neediest groups as a base for making decisions on the desired characteristics of next year's client group. Since it was agreed that the DMA should continue to place primary emphasis on serving economically disadvantaged persons, the number of people in each of the twenty-five groups who were in poverty was determined from 1970 census data (See Table "K"). On the basis of these figures, guideline percentages were calculated for ethnic, sex, age, and head of family distribution.

In reaching its final recommendation, the committee modified these percentages. It again made subjective decisions based upon its knowledge of the Denver community and its opinion on what a manpower program should be. It decided to provide even more service to family heads than the matrix approach indicated because of the great social benefits to be gained by providing stable and adequate family income. Thus, the percentage of clients who will be family heads was raised to 70%. Since the emphasis would be on helping families it was decided to base the ethnic distribution on the number of total persons (including family members) in poverty and on welfare. This resulted in increasing the level of service to Blacks and Chicanos to 30% and 50% respectively. Since it is well documented that women's average income is greatly lower than men, and since the committee had taken out the mean income category from the matrix calculations, it was decided to make 60% of the clients women rather than the 51% which came out of the twenty-five groups most in need. The age distribution was left essentially the same as it came out of the twenty-five groups.

The use of the matrix approach therefore, did not eliminate the need to make subjective decisions. It did provide a way to organize and combine the hard data; it provided a framework which helped clarify thinking about what factors should determine manpower clients and helped isolate the points at which subjective decisions were needed.

APPENDIX IV
TABLE "E"

	% Of Population	% Of Labor Force	Unemployment Rate	% Of Group In Poverty	Mean Income State-Wide	% Of Applicants At Empl. Svce.
Black-Males	4.4	4.4	6.6	21.2	4,788	9.0
Black-Females	4.7	3.9	5.9	28.9	2,925	6.5
Chicano-M	8.2	8.3	6.6	21.5	5,253	12.6
Chicano-F	8.5	4.8	5.2	26.6	2,285	6.3
White-M	42.0	52.1	4.2	10.2	7,303◊	44.6◊
White-F	47.0	38.1	3.5	13.9	3,030◊	21.0◊
Indian-M	.2					
Indian-F	.3					
Other-M*	.6	.9	6.5	20.0	(6,000)	1.5)
Other-F*	.7	.6	3.9	25.4	(2,760)	1.0)
Vets	15.3	32.3+	2.9+	(9.8)	9,676	22.2
Ex-Offender						
> 45 - F	18.0	15.1°	2.9□	15.1	3,428	5.1
> 45 - M	14.0	21.6°	2.9□	9.4	8,339	9.4
22/44 - F	15.3	20.0°	3.3□	12.7	3,425	19.0
22/44 - M	14.3	29.7°	2.9□	8.0	8,337	42.2
16/21 - F	6.1	6.5°	8.4□	17.5	1,440	9.6
16/21 - M	5.2	7.1°	10.8□	16.2	1,921	14.7
Head of House-F	3.4	8.2	(5.2)	32.2	4,425	(8)
Head of House-M	21.4	38.2^	(5.2)	5.7	9,058	(50)
WEIGHTS	1	2	8	10		4

NOTES: Data for American Indians and Ex-Offenders is insufficient to fill in the matrix at this point. Figures in parentheses are estimates.

^Based on the assumption that male family heads participate in the labor force at the same rate as all males (77.1), an assumption which is probably low.
* Includes American Indians in all boxes except % of Total Population.
+ State-wide figure.
° Calculated on basis of total labor force (includes military).
□ SMSA figure.
◊ Includes "Other" races and ethnic groups.

APPENDIX IV

TABLE "F"

	% Of Population	% Of Labor Force	Unemployment Rate	% Of Group In Poverty	% Of Applicants At Empl. Svce. 9/74		Relative Index Of Need
Blacks-Males	9.4	16.9	489	658	40.3	=	1,214
Blacks-Female	10.0	15.0	437	898	29.1	=	1,389
Chicano-M	17.4	31.9	489	668	56.5	=	1,263
Chicano-F	18.1	18.4	385	826	28.3	=	1,276
White-M	89.4	200.0	311	317	200.0	=	1,118
White-F	100.0	164.0	259	432	94.2	=	1,031
Indian-M	.4						
Indian-F	.6						
Other-M	1.3	3.5	481	621	6.7	=	1,114
Other-F	1.5	2.3	289	789	4.5	=	1,086
Vets	32.6	124.0	215	304	99.6	=	775
Ex-Offenders							
> 45 - F	38.3	58.0	215	469	22.9	=	803
> 45 - M	29.8	82.9	215	292	42.5	=	662
22/44 - F	32.6	76.8	244	394	85.2	=	833
22/44 - M	30.4	114.0	215	248	189.0	=	796
16/21 - F	13.0	25.0	622	543	43.0	=	1,246
16/21 - M	11.1	27.3	800	503	65.9	=	1,407
Head of House-F	7.2	31.5	385	1,000	35.9	=	1,460
Head of House-M	45.5	147.0	385	177	224.0	=	979
WEIGHTS	1	2	8	10	2		

Adjusted and weighted figures.

Note: Mean Income figures have been deleted for this revised Table "F".

TABLE "G"

% of Race/Ethnic Group in Given Categories
Frequency Distribution

	Veterans	45+ Female	45+ Male	22-44 Female	22-44 Male	16-21 Female	16-21 Male	Heads of Households w/ Family Female	Heads of Household w/ Family Male
Blacks - Males	27.5		19.8		29.4		10.0		35.9
Blacks - Females		21.6		31.0		10.3		11.7	
Chicano - Males	22.2		15.5		30.5		10.9		37.3
Chicano - Females		16.3		30.3		13.3		8.0	
White - Males	32.9		30.7		30.1		11.2		46.1
White - Females		35.7		28.6		11.6		5.9	
Other - Males	24.8		23.2		34.8		11.1		41.6
Other Females		21.7		37.3		12.8		7.1	
Indian - Males									
Indian - Females									

APPENDIX IV

TABLE "H"

Frequency Distribution Index
Table G Figures Adjusted

	Veterans	45+ Female	45+ Male	22-44 Female	22-44 Male	16-21 Female	16-21 Male	Heads of Households w/ Family Female	Heads of Household w/ Family Male
Black - Males	610		471		617		652		853
Black - Females		442		607		565		1095	
Chicano - Males	493		369		640		710		886
Chicano - Females		333		593		730		749	
White - Males	730		730		631		730		1095
White - Females		730		560		637		552	
Other - Males	550		552		730		723		988
Other Females		444		730		703		664	
Indian - Males									
Indian - Females									

Top weight for each of the first seven categories was set at 730 which is one-half the top weight for economic need (1460, from Table"F"). The top weight for family heads was set at 1095 (three-fourths of 1460) which reflects the increased emphasis the Community Needs Subcommittee felt should be given to family heads.

APPENDIX IV

TABLE "I"

Index Derived from Combination of Figures from Tables F & H

	Veterans 775	45+ Female 803	45+ Male 662	22-44 Female 833	22-44 Male 796	16-21 Female 1246	16-21 Male 1407	Head of Household w/Family Female 1460	Head of Household w/Family Male 979
Black - Male - 1214	1040		939		1051		1309		1218
Black - Female - 1389		1054		1132		1280		1578	
Chicano - Male - 1263	1012		918		1080		1352		1251
Chicano - Female - 1276		965		1081		1301		1394	
White - Male - 1118	1049		1004		1018		1302		1277
White - Female - 1031		1026		970		1166		1217	
Other - Male - 1114	976		931		1056		1298		1232
Other - Female - 1086		933		1060		1214		1284	
Indian - Male									
Indian - Female									

Figures in each box were obtained by adding the appropriate Table "F" indices and the relevant Table "H" index, then dividing that sum by 2.5.

APPENDIX IV

TABLE "J"

Indices of Manpower Need
for Sixty-four Groups

Black - Male - 45+	939
Black - Male - 45+ - Veteran	990
" " " " - Head of Family	1066
" " " - Head of Family	1079
" " - 22-44	1051
" " " - Veteran	1046
" " " " - Head of Family	1103
" " " - Head of Family	1135
" " - 16-21	1309
" " " - Head of Family	1264
Black- Female - 45+	1045
" " " - Head of Family	1316
" " - 22-44	1132
" " " - Head of Family	1355
" " - 16-21	1280
" " " - Head of Family	1429
Chicano-Male - 45+	918
" " " - Veteran	965
" " " " - Head of Family	1061
" " " - Head of Family	1085
" " - 22-44	1080
" " " - Veteran	1046
" " " " - Head of Family	1114
" " " - Head of Family	1166
" " - 16-21	1352
" " " - Head of Family	1302
Chicano-Female-45+	965
" " " - Head of Family	1180
" " - 22-44	1081
" " " - Head of Family	1238
" " - 16-21	1301
" " " - Head of Family	1348
White - Male - 45+	1004
" " " - Veteran	1027
" " " " - Head of Family	1110
" " " - Head of Family	1141
" " - 22-44	1081
" " " - Veteran	1034
" " " " - Head of Family	1115
" " " - Head of Family	1148
" " - 16-21	1302
" " " - Head of Family	1290
White - Female-45+	1026
" " " - Head of Family	1122
" " - 22-44	970
" " " - Head of Family	1094
" " - 16-21	1166
" " " - Head of Family	1192

(Continued next page)

APPENDIX IV
Table "J" Continued

Other	- Male	- 45+			931
"	"	"	- Veteran		954
"	"	"	"	- Head of Family	1046
"	"	"	- Head of Family		1082
"	"	- 22-44			1056
"	"	"	- Veteran		1016
"	"	"	"	- Head of Family	1088
"	"	"	- Head of Family		1144
"	"	- 16-21			1298
"	"	"	- Head of Family		1265
Other	- Female	- 45+			933
"	"	"	- Head of Family		1109
"	"	- 22-44			1060
"	"	"	- Head of Family		1172
"	"	- 16-21			1214
"	"	"	- Head of Family		1249

APPENDIX IV

TABLE "K"

Numbers of Persons in Poverty (1970)
In the Twenty-five Target Groups

ETHNIC	SEX	AGE	HEAD OF FAMILY	NUMBER IN POVERTY
Black	Female	16-24	Yes	241
Black	Female	25-44	Yes	875
Chicano	Female	16-24	Yes	404
Black	Female	45 +	Yes	303
Chicano	Male	16-24	Yes	397
Anglo	Male	16-24	Yes	690
Other	Male	16-24	Yes	40
Black	Male	16-24	Yes	139
Other	Female	16-24	Yes	19
Chicano	Female	25-44	Yes	1,118
Anglo	Female	16-24	Yes	394
Chicano	Female	45 +	Yes	511
Other	Female	25-44	Yes	59
Chicano	Male	25-44	Yes	1,100
Anglo	Male	25-44	Yes	732
Other	Male	25-44	Yes	74
Anglo	Male	45 +	Yes	1,744
Chicano	Male	16-24	No	1,307
Black	Male	16-24	No	609
Anglo	Male	16-24	No	3,638
Chicano	Female	16-24	No	1,551
Other	Male	16-24	No	130
Black	Female	16-24	No	748
Other	Female	16-24	No	159
Anglo	Female	16-24	No	4,474
				21,456

APPENDIX V

SYSTEM DESIGN SUBCOMMITTEE MATRIX

	B/W -M/F 22-44	C -M/F 22-44	B/W -M/F 16-21	C -M/F 16-21	B/W/C -M 45 +	B/W/C -F 45+	TOTAL	% OF TOTAL
ndividuals Served								
Percent	24.9	27.1	19.2	20.8	4.8	3.2	100	
Number	299	325	230	250	58	38	1200	
ntake - $124								
Percent	100	100	100	100	100	100		100
People	299	325	230	250	58	38	1200	
ounseling - $413								
Percent	100	100	100	100	100	100		100
People	299	325	230	250	58	38	1200	
rientation W/Stipend $239								
Percent	50	75	100	100	25	75		76.4
Number	149.5	243.73	230	250	14.5	28.5	916.23	
Adult Basic Education /Stipend $714								
Percent	10	50	-0-	20	10	10		21
Number	29.9	162.5	-0-	50	5.8	3.8	252	
ork Sample /Stipend $200								
Percent	20	10	40	70	-0-	-0-		29.9
Number	59.8	32.5	92	175	-0-	-0-	359.3	
Vocational Education (In-House) /Stipend $936								
Percent	10	15	25	23	-0-	10		16.5
Number	29.9	48.7	57	57.5	-0-	3.8	197.45	
ocational Education (Schools) - $1,327								
Percent	25	40	15	22	5	40		26
Number	74.75	130	34.5	55	2.9	15.2	312.35	
On-the-Job Training $1,230								
Percent	5	10	10	15	5	10		9.6
Number	14.95	32.5	23	37.5	2.9	3.8	114.65	
Work Training Experience $1,255								
Percent	10	10	20	20	5	10		13.8
Number	29.9	32.5	46	50	2.9	3.8	165.1	
Job Development $314								
Percent	90	90	90	90	70	90		89
Number	269.1	292.5	207	225	40.6	34.2	1068.4	

1976 REPORT TO THE GOVERNOR

RICHARD D. LAMM,
Governor

STATE EMPLOYMENT AND TRAINING SERVICES COUNCIL
JOHN I. LAY, Chairman

MANPOWER REPORT TO THE GOVERNOR
FISCAL YEAR 1976

TABLE OF CONTENTS

CETA - AN OVERVIEW

The Act

On December 28, 1973, the 93rd Congress of the United States enacted the Comprehensive Employment and Training Act (CETA). CETA provides a decentralized approach in the provision of employment and training opportunities. For the first time state and units of local government were given the authority to exercise their judgement and expertise in the operation of manpower program designs and operations geared to the specific needs of the population of their jurisdiction.

Generally, a municipality of 100,000 or more people can elect to be a CETA prime sponsor, thereby enabling the municipality to be a direct recipient of funds from the Federal Government. In addition, there are provisions allowing municipalities having common political boundaries to group together, forming a consortium, providing that at least one of the consortium members qualifies as a prime sponsor in its own right.

CETA consists of seven seperate titles for which a brief description is provided.

Description of CETA Titles

Title I

The purpose of this title is to establish a program to provide comprehensive manpower services, which would enhance the development and creation of job opportunities. Manpower activities such as classroom training, on-the-job training, work experience, and other services to applicants are provided to persons who are economically disadvantaged, unemployed, and underemployed.

Title II

It is the purpose of this title to provide unemployed and underemployed persons with transitional employment in jobs providing needed public serivces in areas of substantial unemployment and, wherever feasible, related training and manpower services to enable such persons to move into employment or training not supported under this title.

Title III

This title established special federal responsibilities in the provision of additional manpower services to nationally selected target groups that are in particular need of such services, including youth, offenders, persons of limited English-speaking ability, older workers, and other persons which the Secretary determines have particular disadvantages in the labor market.

Special manpower programs have also been established by this title to meet the specific needs of the Indian and migrant and seasonal farmworker.

Finally, this title authorizes the implementation of the Summer Program for Economically Disadvantaged Youth which provides short term employment opportunities.

Title IV

This title establishes a Job Corps for low-income disadvantaged young men and women. The purpose of this title is to assist young persons (16-21 years) who need and can benefit from an unusually intensive residential employment program to become more responsive, employable, and productive citizens.

Title V

The purpose of this title is to establish a National Commission for Manpower Policy which will have the responsibility for examining national employability issues and for advising the Secretary on national manpower issues.

Title VI

This title provides for the establishment and operation of a public service employment and manpower training program under the Emergency Jobs and Unemployment Assistance Act of 1974.

This program, which is necessitated by the increase in unemployment rates, is designed to have an immediate impact at the local level. By making funds available for a specific, limited period of time, and allowing local governments increased flexibility in the use of these funds, it is possible to quickly provide a maximum number of individuals with public employment opportunities.

Title VII

This last title provides general provisions such as definitions, legal authority and other items of general nature that normally accompanies such legislation.

ECONOMIC OVERVIEW - - THE YEAR IN REVIEW

Substantial progress was made during 1976 as the state's economy recovered from the worst national recession in nearly 40 years.

With one exception, every sector registered net gains in employment in 1976. The fastest growing sector was mining with 1,800 new jobs added, an increase of 9.8% over 1975. This is noteworthy in light of the fact that mining was the fastest growing sector in 1975 as well.

In absolute terms, the services sector registered the largest gain with 11,000 new jobs. The trade sector was second with 10,600 jobs.

The construction sector continued its decline of 1974 and 1975, dropping by 800 jobs. This represents, however, a slowdown in the rate of decline over recent years as it dropped only 1.4%.

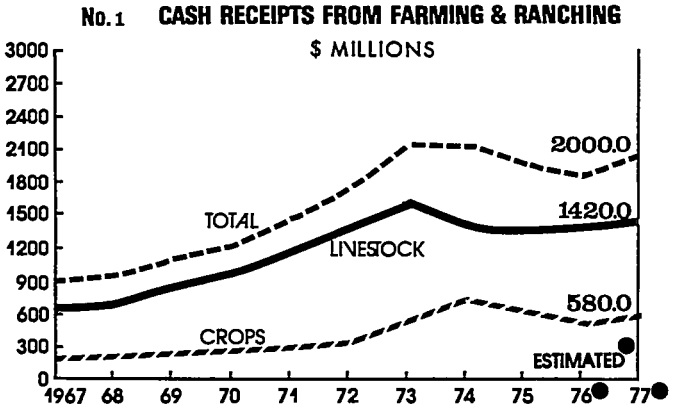
On balance for 1976, Colorado recovered well from the downturn in 1974 and early 1975. The increase in jobs of 38,600 is 7,600 beyond what was predicted in 1975. All things considered, the Colorado economy is now in a state of relatively good health.

Information provided in this section on Colorado business and industry was extracted from the Colorado Business Economic Outlook Forum.

AGRICULTURE

A significant portion of Colorado's primary income orginates in the agricultural sector. The State's crop and livestock output provides the raw materials for a number of major Colorado industries, as well as supplying part of the requirements for national and international markets.

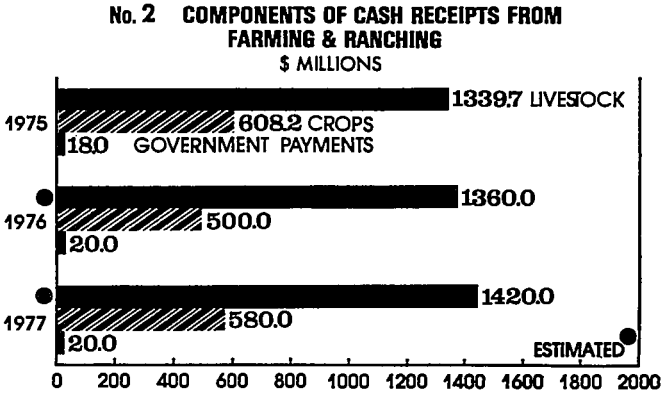
Chart 1 shows that cash receipts from farming and ranching, including feed cattle operations, are expected to rise 7.5% to $2.0 billion in 1977. This is still considerably below the record years of 1973 and 1974. The drop in cash receipts which occurred in 1975 and 1976 after nearly 15 years of continually rising receipts has been halted, and signs of recovery are present in both the livestock and crop sectors.



The dollar value of livestock receipts shows a 1.5% rise in 1976 to $1.36 billion (see chart 2). The increase in 1977 will be $60 million, raising the total to $1.42 billion. Cattle and calves account for slightly more than four-fifths of livestock receipts and nearly two-thirds of total agricultural cash receipts. Increase in the volume of pork marketed, along with improvements in fed cattle prices, should enhance agriculture income.

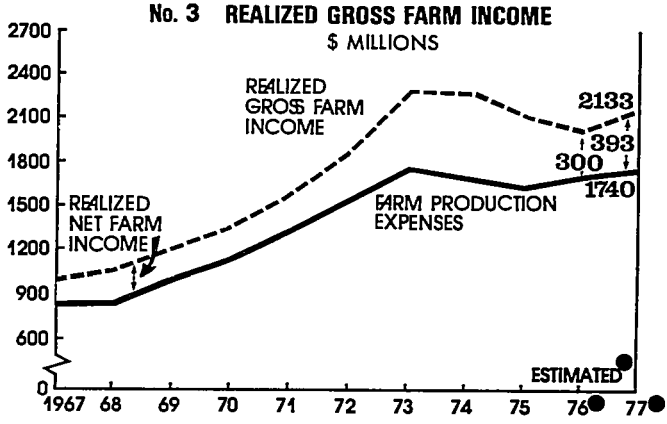
Crop receipts exhibited a very sizable decline in 1976 of over $108 million, bringing the total to $500 million. This reflects not only the lower volume of wheat and feed gains marketed, but also the reduced prices for most crops.

The government payment component of agricultural cash receipts will increase slightly in 1976 to $20 million and remain at that level in 1977.



Realized gross farm income, which includes cash receipts, government payment, and farm production consumed on the farm totaled $1.99 billion in 1976, down 4 percent from 1975, and is expected to rise to $2.13 billion in 1977, as shown in Chart 3. Production expenses rose 5 percent during 1976 to $1.69 billion leaving a realized net farm income of $300 million, down 35 percent from 1975 and the lowest since 1972.

Agricultural employment has been declining since the early 1970's. It has stabilized during the last two years, however, at 50,000 jobs. This figure may decline if the forecasted drought continues.



MINING

The mineral industry and its related supportive activities play a vital role in the economics of the rural areas of Colorado. The mining sector is experiencing the greatest relative advance in employment with a 9.8% increase in 1976 and an additional 10.0% increase forecast for 1977. Production values of metals, non-metals, crude petroleums, and natural gas are at their highest levels.

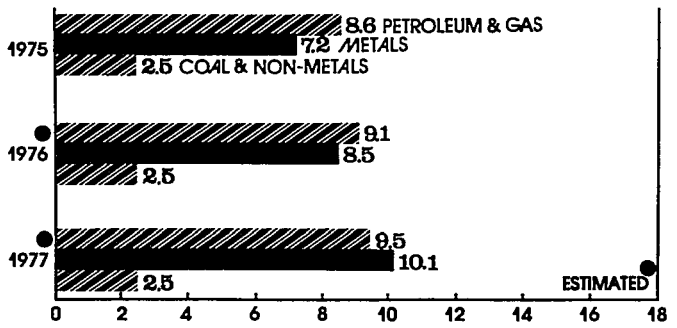
The largest concentration of mining employment in Colorado was in petroleum and natural gas in 1976, with a total of 9,100 employed. Employment in petroleum and gas will increase by 400 in 1977 to a total of 9,500. Chart 4 indicates that this relationship will change in 1977 as metals overtake petroleum and natural gas employment. Employment in metals will rise dramatically adding 1,600 new jobs, for a total of 10,100. This is due to expansion of existing metal operations and new enterprises such as AMAX's Henderson mine and mill.

Finally, employment in the bituminous coal and non-metals industry will provide a minimum of 2,500 jobs in 1977 with the anticipation of many more in the foreseeable future.

COLORADO MINING EMPLOYMENT
1960 - 1977

Year	Metals	Non-Metals	Petroleum and Natural Gas	Total Mining Employment	Percent Change
1960	6,300	2,600	6,500	15,400	0.6%
1961	6,400	2,000	6,100	14,500	- 5.8
1962	5,000	1,900	5,800	12,700	-12.4
1963	5,000	1,800	5,200	12,000	- 5.5
1964	5,200	1,900	4,800	11,900	- 0.8
1965	5,500	2,000	4,900	12,400	4.2
1966	5,800	2,000	5,000	12,800	3.2
1967	5,900	1,900	5,200	13,000	1.6
1968	5,600	1,900	5,600	13,100	0.8
1969	5,400	1,900	6,200	13,500	3.1
1970	5,700	2,000	6,300	14,000	3.7
1971	5,300	2,000	6,100	13,400	- 4.3
1972	5,100	2,300	6,500	13,900	3.7
1973	5,100	2,300	7,300	14,700	5.8
1974	6,000	2,400	7,900	16,300	10.9
1975	7,200	2,500	8,600	18,300	12.3
1976*	8,500	2,500	9,100	20,100	9.8
1977*	10,100	2,500	9,500	22,100	10.0

No. 4 COMPONENTS OF MINING EMPLOYMENT
(000)



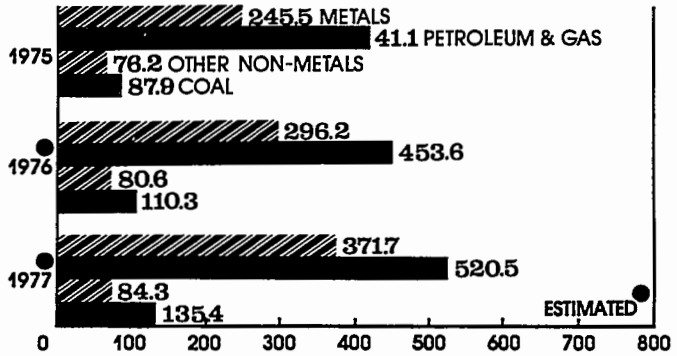
A 20.7% increase in metal production during 1976 will be followed by a larger rise of 25.5% for 1977 to a total of $371.7 million. Physical output of molybdenum will grow the fastest, with an increase of 21.1% in 1977. This is due to good market conditions and the expanded production facilities of AMAX's Molybdenum operations. The output of crude oil dropped in 1976. This is a direct result of the lack of new oil deposits being discovered.

VALUE OF MINERAL PRODUCTION IN COLORADO
1960 - 1977
(Millions of Dollars)

Year	Metals	Non-Metals	Coal, Oil & Gas	Total
1960	$152.6	$39.2	$184.5	$ 376.3
1961	170.2	43.5	183.0	396.7
1962	126.8	46.7	164.0	337.5
1963	139.5	47.9	153.5	340.9
1964	150.1	47.6	140.3	338.0
1965	154.3	47.8	143.2	345.3
1966	172.0	49.2	145.1	366.3
1967	174.2	47.6	149.5	371.3
1968	177.1	48.7	150.9	376.7
1969	172.8	35.1	149.3	357.2
1970	190.2	49.7	132.0	371.9
1971	177.4	59.5	139.5	376.4
1972	168.9	68.6	168.8	406.3
1973	159.7	80.8	386.2	626.7
1974	218.3	73.7	406.0	698.0
1975	245.5	76.2	499.0	820.8
1976*	296.2	80.6	563.9	940.8
1977*	371.7	84.3	655.9	1,111.9

* Estimated

No. 5: COMPONENTS OF MINERAL PRODUCTION
$ MILLIONS



MANUFACTURING

Growth in the manufacturing sector will continue to provide a major stimulus to the Colorado economy in 1977 as it did in 1976.

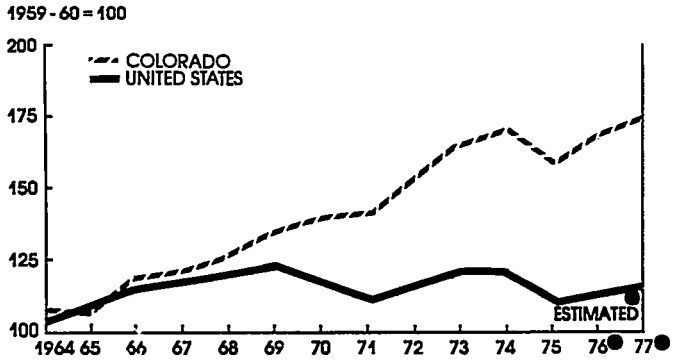
During the 10-year period 1965-1974, Colorado manufacturing employment expanded rapidly, only to be reversed in 1975 because of the national recession with a loss of 9,100 jobs. In 1976, 6,500 jobs were recovered.

COLORADO MANUFACTURING EMPLOYMENT
BY INDUSTRY GROUPS
1973 - 1977
(In Thousands)

Industry Group	1973	1974	1975	1976*	1977*	Percent Change 1977
Machinery, Including Electrical	30.7	33.1	29.8	30.7	31.7	3.3%
Food/Kindred Products	22.9	23.6	23.8	25.0	25.5	2.0
Textiles/Apparel/Leather	7.0	7.6	6.6	7.6	7.8	2.6
Printing/Publishing/Allied Ind.	11.6	12.0	11.6	11.6	11.8	1.7
Chemicals/Allied Products	2.3	2.6	2.8	3.0	3.1	3.3
Rubber/Misc. Plastic Products	7.3	7.3	6.3	6.5	6.6	1.5
Ordnance/Accessories	10.3	9.0	7.4	7.7	7.7	0.0
Lumber/Wood Products	6.1	5.7	5.2	5.2	5.5	5.8
Stone/Clay/Glass Products	8.9	9.1	8.3	8.6	9.2	7.0
Primary Metal Industries	8.5	8.5	8.5	8.4	8.3	-1.2
Fabricated Metal Products	9.0	8.9	8.5	9.4	10.0	6.4
Transportation Equipment	4.7	4.4	3.6	3.6	3.8	5.6
Other Durable/Nondurable Goods	10.6	12.3	12.5	14.2	14.7	3.5
TOTAL MANUFACTURING[a]*	140.0	144.0	134.9	141.5	145.7	3.0

[a] Totals may not add up due to rounding.
* Estimated

No.6 INDEX OF MANUFACTURING EMPLOYMENT COLORADO AND UNITED STATES



CONSTRUCTION

The increased construction activity in Colorado in 1976 paralleled the national trend, with residential construction leading the way. Residential building in Colorado will finish 1976 with 38.6% increase over 1975. In the last half of 1976 apartment starts were beginning to appear stronger after a noticeable two-year absence. Apartment starts have been one of the weakest spots in the housing recovery.

There were 56,000 workers employed in Colorado's construction sector in 1976 - 800 fewer than in 1975. Construction employment has declined over 16,000 jobs since 1972.

EMPLOYMENT IN CONSTRUCTION
COLORADO AND UNITED STATES
1959 - 1977
(In Thousands)

(Base Year) 1959 - 1960 = 100

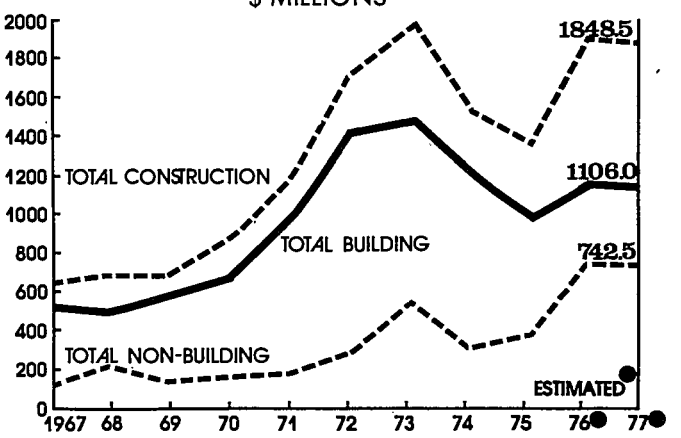
Year	Index	Colorado	Percent Change	Index	United States	Percent Change
1959	100	33.7	- 0.9%	101	2,960.0	6.6%
1960	100	33.5	0.6	99	2,885.0	- 2.5
1961	111	37.3	11.3	96	2,816.0	- 2.4
1962	107	35.8	- 4.0	99	2,902.0	3.1
1963	110	36.9	3.1	101	2,963.0	2.1
1964	110	37.0	0.3	104	3,050.0	2.9
1965	110	37.0	0.0	109	3,186.0	4.5
1966	107	36.1	- 2.4	112	3,275.0	2.8
1967	102	34.3	- 5.0	110	3,208.0	- 2.0
1968	109	36.7	7.0	113	3,306.0	3.1
1969	113	38.1	3.8	121	3,525.0	6.6
1970	122	41.1	7.9	121	3,536.0	0.3
1971	143	48.2	17.3	125	3,639.0	2.9
1972	188	63.3	31.3	131	3,831.0	5.3
1973	215	72.1	13.9	137	4,015.0	4.8
1974	196	66.0	- 8.5	135	3,957.0	- 1.5
1975	169	56.8	-13.9	118	3,457.0	-12.6
1976*	167	56.0	- 1.4	116	3,400.0	- 1.7
1977*	166	55.8	- 0.4	122	3,550.0	4.4

* Estimated

The value of total construction in Colorado in 1976 is up a substantial 35.6% from 1975 and will total over 1.86 billion.

Non-building construction in Colorado will be helped with huge projects in the energy-related fields. A $500 million contract was let in 1976 for the Colorado/Ute Salt River project power plant near Craig, Colorado. Two power plant projects will account for $340 million of the estimated total of $742 million for 1977. It should be noted that the total cost of construction projects are recorded in the year contracts are awarded rather than on a percentage completion basis.

No.7 VALUE OF CONSTRUCTION IN COLORADO



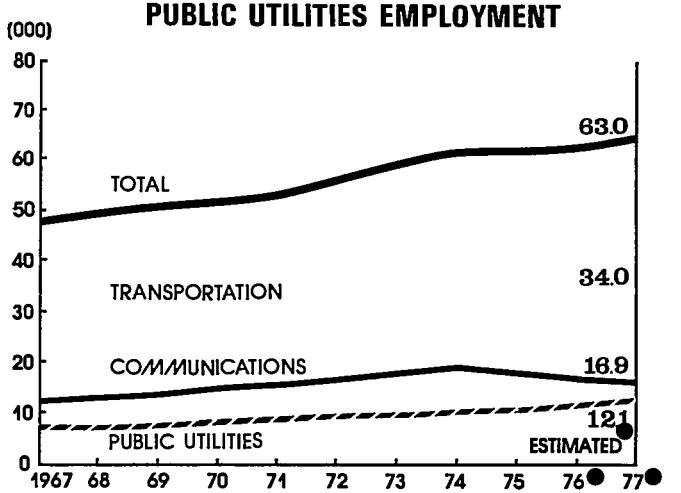
The activities included in the transportation, communication and public utilities sector are quite diverse, and as a group they are a major employer in the state.

The level of activity in the transportation, communication and public utilities sector increased by 1,600 jobs during 1976 after a loss of 1,200 jobs in 1975, bringing the total employment in this sector to 63,000.

Employment in the communication sector declined by 600 jobs in 1976 because of a slowdown in expenditures for capital and labor. Employment has decreased 6.6% since 1974, the largest decline since the mid-1950's.

Employment in electric, gas, and sanitary services sector increased by 700 jobs in 1976.

No.8 TRANSPORTATION, COMMUNICATION AND PUBLIC UTILITIES EMPLOYMENT



FINANCE, INSURANCE AND REAL ESTATE

A healthy financial environment is a key element in the economic development of any state. For this reason the 1973-1974 period was particularly troublesome since financial institutions nationwide suffered from insufficient deposit growth to meet the needs of their customers. This problem was reversed in 1975-1976 as the uncertain economic environment encouraged both consumers and business to improve their liquidity. The improved but still worrisome economic climate in 1977 will result in a posture of liquidity - - maintenance by both consumers and business. In general, the finance, insurance, and real estate sector will experience a good year in 1977. It will be aided by continued moderate inflation, only a gradual rise in short-term interest rates, and an ample supply of funds.

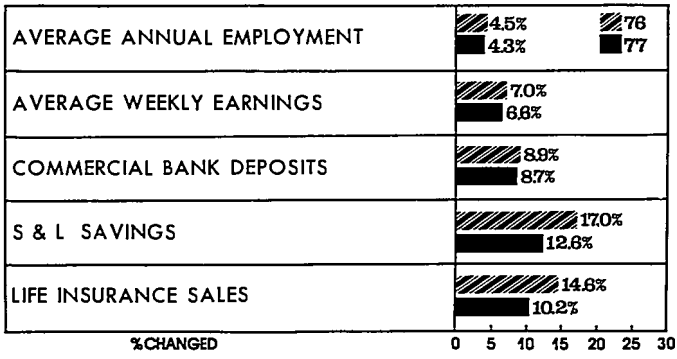
Commercial bank deposits showed rapid growth in the early 1970's but slower growth since 1973. Commerical bank deposits rose in 1976, with most of the growth coming from savings deposits.

Life insurance sales have exhibited very strong growth over the years – except for 1974 and 1975. To some extent, the rapid inflation of 1974 and 1975 probably resulted in delayed purchases of life insurance since the money was used for more immediate needs. Once real income began to rise again in 1976, however, life insurance sales experienced a burst of growth. In fact, during 1976 sales rose 14.6%

Savings in Colorado savings and loan associations has experienced the sharpest growth. This is a reflection of consumer attempts to become more liquid, with the volume of savings rising by 17% in 1976.

After two very slow years in 1974 and 1975, employment in finance, insurance and real estate jumped 4.5% in 1976. Part of the reason for this growth was the increased real estate and insurance activity. Average weekly earnings of those employed in this industry have risen 7.0% in 1976.

No.9 EXPECTED CHANGES IN FINANCE, INSURANCE AND REAL ESTATE



TRADE AND SERVICES

The trade group accounts for the largest segment of Colorado's employment. Activity in retail and wholesale trade depends upon general levels of income and spending rates, but, unlike some of the primary sectors, is not overly sensitive to year-to-year changes in employment.

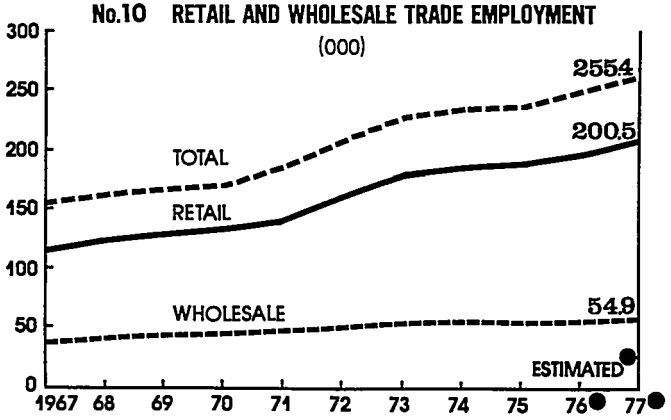
In addition to strong employment gains expected in 1977, substantial increases are also expected in retail sales. Retail sales will grow by 10.7% in 1976 to $16.1 billion. An additional gain of 11.3% is expected for 1977, with retail sales reaching $17.9 billion.

Consumers are being depended on to increase their purchase of durable and nondurable goods in 1977.

The broad collection of economic activities labeled "service group" includes establishments primarily engaged in providing a wide variety of services for individuals, businesses, government, and other organizations.

Employment in business and personal services will increase in 1977 to a total of 204,000. The service sector continues to be one of the steady performers in 1977 Colorado outlook.

In conclusion, there will be 459,400 employed in the trade and services sectors in 1977. These two sectors account for two of every five non-agricultural jobs in Colorado, or nearly 45% of the state's total employment.



TOURISM, OUTDOOR RECREATION, AND CONVENTIONS

Tourism, outdoor recreation, and conventions, while not a standard sector classification, are treated separately because of their importance in the Colorado economy. These activities have a significant impact statewide, but tourism and outdoor recreation are particularly important in the rural areas of the state, expecially in Western Colorado

The Big Thompson flood, the snow drought experienced by Colorado ski areas, and a decrease in the state's advertising and promotional budget combined to materially reduce

the projected growth in tourism in 1976, which means that 1977 will start with a lower base than would normally be expected. Rising costs in transportation, competition from other vacation destinations, and potential changes in travel patterns and habits make the growth outlook for the travel industry in 1977 tenuous at best.

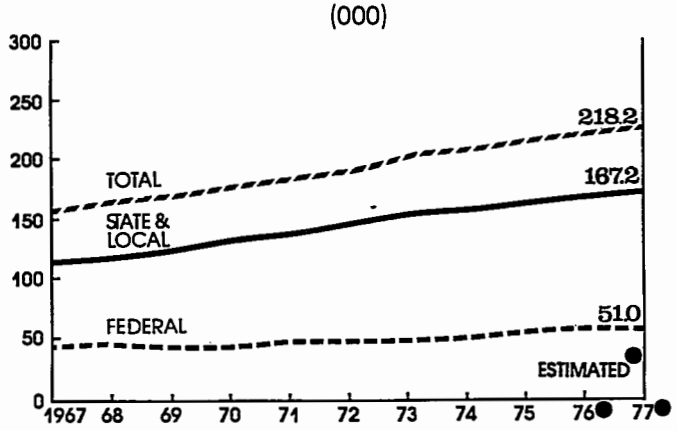
GOVERNMENT

Employment in local, state, and federal government in Colorado is the second largest sector. More than one out of every five nonagricultural employees in 1976 were employed by the government sector. The number has increased rapidly in recent years but now appears to be stabilizing. Several factors are responsible for government employment growing at a slower pace. Federal civilian government employment is dropping slightly in Colorado because of a hold on spending and the continued phaseout of production at the Pueblo Army Depot. State and local government employment will grow modestly since funding is not available for additional programs in 1977.

Wages and salaries paid to government employees provide a solid contribution to the state's purchasing power, Government wages and salaries will total $3.02 billion in 1977. Federal wages and salaries will total nearly $1.32 billion, and state and local payments will increase to $1.70 billion.

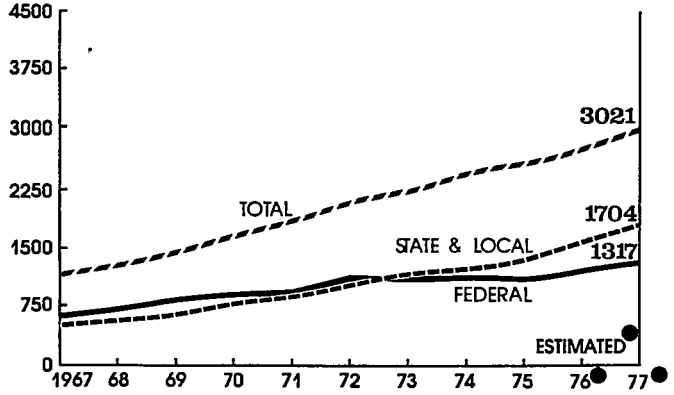
Revenue Sharing funds will continue to be an important source of funds for local government spending in Colorado in 1977. Federal/local programs such as the Comprehensive Employment and Training Act (CETA), additional temporary federal spending programs within the area of employment and training, and additional property tax receipts from growth in the assessed valuation will help support local government expenditures.

No.12 GOVERNMENT EMPLOYMENT



No.13 GOVERNMENT WAGES AND SALARIES

$ MILLIONS



SUMMARY

Although there has been a healthy recovery during 1976 from the recession as measured by employment trends, few sectors of the Colorado economy hold real promise of exceptional strength over the short term. Consumer spending will be limited by the eroding effect of inflation on incomes, capital investment awaits its potential expansion, and financial constraints and budget policy may restrict government spending.

NEW JOBS CREATED IN NONAGRICULTURAL WAGE AND SALARY EMPLOYMENT SECTORS

INDUSTRY	BEST YEAR	POOREST YEAR	AVERAGE ANNUAL CHANGE 1965-75	1976	1977
MINING	2000 75	-1800 62	590	1800	2000
MANUFACTURING	11200 72	-9100 75	4490	6500	4300
CONSTRUCTION	15100 72	-9200 75	1980	-800	-200
TRANSPORTATION & PUBLIC UTILITIES	3600 73	-1200 75	1520	1600	1600
FINANCE, INSURANCE & REAL ESTATE	7400 73	-400 75	2500	2500	2500
RETAIL & WHOLESALE TRADE	22200 72	1600 61	9590	10600	8600
SERVICE INDUSTRIES	17000 72	3300 75	8230	11000	9700
GOVERNMENT	10300 66	3400 64	7380	5400	2600
TOTAL	80800 72	-2300 75	36280	38600	31100

All figures in thousands unless otherwise indicated. An asterisk (*) indicates preliminary data subject to revision. Revised data are marked (r).

	September 1976	August 1976	September 1975	Percent September August 1976	Change 1976 from September 1975
Total Labor Force (by place of residence)	1,192.7	1,198.2r	1,180.4r	- 0.5	1.0
Unemployment	66.8	69.2r	75.6r	- 3.5	- 11.6
Unemployment Rate (percent)	5.6	5.8	6.4r	------	------
Employment	1,125.9	1,129.0r	1,104.8r	- 0.3	1.9
Agricultural	63.9	63.9	64.0	00	- 0.2
Nonagricultural Wage and Salary	973.2	972.9r	952.4r	0.0	2.2
All Other	88.8	92.2r	88.4	- 3.7	0.5
Total Nonagricultural Wage and Salary Employment: (by place of work)	981.8	979.7r	960.2	0.2	2.2
Mining	20.4	20.6r	19.1	- 1.0	6.8
Metal	8.6	8.7	7.7	- 1.1	11.7
Coal, Quarrying and Nonmetallic	2.6	2.6	2.2	0.0	18.2
Petroleum and Gas	9.2	9.3r	9.1	- 1.1	1.1
Contract Construction	58.7	59.2r	62.8	- 0.8	- 6.5
Manufacturing	140.2	141.7	136.2	- 1.1	2.9
Food and kindred Products	25.2	25.5	24.4	- 1.2	3.3
Textiles, Apparel, and Leather	7.1	7.1	6.8	0.0	4.4
Chemicals and Allied Products	3.1	3.1	2.9	0.0	4.4
Rubber and Plastic Products	6.3	6.2r	6.3	1.6	0.0
Printing and Publishing	11.6	11.4	11.3	1.8	2.7
Ordnances and Accessories	6.8	6.8r	7.2	0.0	- 5.6
Lumber, Wood, and Furniture	5.7	5.8	5.6	- 1.7	1.8
Stone, Clay, and Glass Products	8.8	9.0r	8.7	- 2.2	1.2
Primary Metal Products	8.3	8.8	8.5	- 5.7	- 2.4
Fabricated Metal Products	8.5	8.8r	8.8	- 3.4	- 3.4
Machinery, Except Electrical	16.2	16.2	15.8	0.0	2.5
Electrical Machinery	14.4	14.7	13.7	- 2.0	5.1
Transportation Equipment	3.6	3.7	3.8	- 2.7	- 5.3
Other Durable and Nondurable	14.6	14.7	12.4	- 0.7	17.7
Finance, Insurance, and Real Estate	59.9	60.1r	56.8	- 0.3	5.5
Bank and Credit Agency	23.2	23.2r	22.5	0.0	3.1
Insurance Carriers, Agents and Brokers	16.1	16.0r	15.1	0.6	6.6
Real Estate and Combination Offices	17.8	17.9	16.3	- 0.6	9.2
Other Finance, Insurance, and Real Estate	2.9	2.9	2.8	0.0	3.6
Transportation and Utilities	61.5	61.3r	60.8	0.3	1.2
Railroads	6.4	6.4r	6.3	0.0	1.6
Motor Freight and Warehousing	14.0	14.1r	14.0	- 0.7	0.0
Air	8.4	8.3	8.2	1.2	2.4
Other Transportation	4.2	4.2	3.7	0.0	13.5
Communications	16.8	16.5r	17.5	1.6	- 4.0
Electric Gas and Sanitary	11.6	11.7	11.0	- 0.9	5.5
Trade	234.0	236.0r	231.2	- 0.8	1.2
Wholesale Trade	50.3	51.0r	49.3	- 1.4	2.0
Retail Trade	183.7	185.0r	181.9	- 0.7	1.0
Services and Miscellaneous	196.7	197.9r	185.8	- 0.6	5.9
Lodging Places	18.7	20.2r	18.6	7.4	0.5
Medical and Health	54.1	54.3r	52.3	- 0.4	3.4
Laundries, Cleaning and Dyeing	4.0	4.0r	4.2	0.0	- 4.8
Miscellaneous Business and Repair	39.9	39.8r	38.8	0.3	4.2
Amusement and Recreation	14.4	14.9r	11.7	- 3.4	23.1
Educational Service	10.5	9.1r	10.2	15.4	2.9
Other Service	55.0	55.7	50.5	- 1.3	8.9
Government	210.1	202.8r	207.6	3.6	1.2
Federal	51.2	52.0r	51.7	- 1.5	- 1.0
State	51.2	51.1r	49.6	0.2	3.2
Local	107.8	99.7	106.8	8.1	1.5

	September 1976	August 1976	September 1975	Percent September August 1976	Change 1976 from September 1975
Average Weekly Hours					
Construction	37.5	36.2	37.6	- 1.8	- 0.3
Mining	42.9	42.6r	40.9	0.7	4.9
Manufacturing	39.6	39.9r	39.9	- 0.8	- 0.8
Food and Kindred Products	41.2	42.7	42.2	- 3.5	- 2.4
Ordnance and Fabricated Metal	40.7	40.5r	40.5	0.5	0.5
Communications and Utilities	41.8	41.7r	40.2	0.2	4.0
Wholesale Trade	39.5	39.6r	39.7	- 0.8	- 0.5
Retail Trade	35.7	36.3	36.6	- 1.7	- 2.5
Lodging Places	29.9	31.6r	28.8	- 5.4	3.8
Average Weekly Earnings ($)					
Mining	260.40	260.71r	242.54	- 0.1	7.4
Construction	310.88	310.95r	301.93	- 0.0	3.0
Manufacturing	213.44	213.47r	206.68	- 0.0	3.3
Finance and Insurance	164.44	161.43r	150.65	- 4.3	2.5
Communications and Utilities	256.65	253.54r	227.93	1.2	12.6
Wholesale Trade	205.80	208.55r	198.50	- 1.3	3.7
Retail Trade	143.87	150.65r	139.45	- 1.2	6.8
Lodging Places	77.14	78.68r	71.71	- 2.0	7.6
Initial Unemployment Claims (000)	10.8	10.8	11.7	0.0	- 7.7
Bankruptcies, All Types (no.)	330	349	410	- 5.4	-19.5
Total State Revenue ($000)	236.186	161.533	189.910	46.2	24.4
Total State Expenditures ($000)	198.476	158.061	189.085	25.6	5.0
Crude Oil Production (thous. bbls.)	3.269	3.288	3.155r	- 0.6	3.6
Dry Gas Production (mil. cu. ft.)	9.681	12.714	8.964r	-23.9	8.0
Coal Production (thous. tons)	865.5	909.4	841.8	- 4.8	14.7
New Oil and Gas Wells (no.)	115	145	90	-20.7	27.8
Natural Gas Used (bil. cu. ft.)	16.5	13.3	16.6	24.1	- 0.6
Electric Power Used (mil. kwh)					
Industrial	424.5	447.4	272.2	- 5.1	n.c.
Commercial	446.4	448.4	443.3	- 0.4	n.c.
Residential	348.1	354.4	294.0	- 1.8	n.c.
New Construction 52 cities					
Residential (no.)	1,100	1,116r	912	- 1.3	20.6
Residential value ($000)	34.471	40.660r	25.227	-15.2	36.6
Nonresidential (no.)	144	115	110	24.1	30.9
Nonresidential value ($000)	17.140	25.990	25.517	-34.1	-32.8
Highway Contractor Payments ($000)	23.068	14.478	15,256	59.3	51.2
Ordinary Life Insurance Sales ($000)	264.790	259.396	257.934r	2.1	2.7
Bank Debits, 82 cities ($000.000)	13.358*	13.372r	13.053r	- 0.1	2.3
S & L Net New Savings ($000)	68.452	34.393	53.133	99.0	28.8
National Park Visits (000)	689.3	1.345.1	680.7	-48.8	1.3
Motor Vehicle Title Applications (000)	74.3	79.1	74.6	- 6.1	- 0.4
Highway Vehicles (daily average)	40.895	57.318	38.321	-28.7	6.7
Air Passengers, Denver (000)	1.094	1.452	966	-24.7	13.3
Air Freight, Denver (thous. lbs.)	19.977	20.389	18.180	- 1.8	9.8
Air Express, Denver (thous. lbs.)	187	163	345	14.7	-45.8

Prices Received by Farmers (S)					
Beef Cattle (per cwt)	37.30	36.60	38.80	1.9	- 3.9
Lambs (per cwt)	43.50	43.00	42.00	1.2	3.6
Hogs (per cwt)	n.a.	n.a.	58.00	----	----
Wheat (per bu.)	2.59	2.67	3.52	- 3.0	-26.4
Corn (per bu.)	2.59	2.75	2.93	- 5.8	11.6
Potatoes (per cwt)	3.25	3.50	3.30	- 7.1	- 1.5
Wool (per lb.)	.78	.78	.57	0.0	36.8
Eggs (per doz.)	n.a.	n.a.	.49	-----	-----

[a] "All other" includes proprietors, members of unincorproated firms, self-employed, unpaid family workers, and domestics working in private households.

[b] New series starting in January 1976.

[c] Ten parks reporting in 1976. Nine reported in 1975.
n.a. — not available
n.c. — not comparable

Employment. Hours and Earnings data from the Colorado Division of Employment in cooperation with the Bureau of Labor Statistics.
Bankruptcies from the Office of the Federal Referee in Bankruptcy.
Total State Revenue and Expenditures from the State Controller's Office.
Crude Oil Production. Dry Gas Production and New Oil and Gas Wells from the Oil and Gas Conservation Commission.
Coal Production from Colorado State Coal Mine Inspection, Department.
Natural Gas Used from Colorado Interstate Gas Company.
Electric Power data from Colorado Springs Department of Public Utilities. Public Service Company of Colorado. Southern Colorado Power Company. Intermountain Rural Electric Association. Union Rural Electric Association. Empire Electric Association. Morgan County Rural Electric Association. Yampa Valley Electric Association, San Luis Valley Rural Electric Cooperative. Holy Cross Electric Association. Poudre Valley Rural Electric Association. Mountain View Electric Association. Highline Electric Association. San Isabel Electric Services. Inc., and Southeast Colorado Power Association.
Construction Value and Number and Bank Debits from individual reporting cities and banks.
Highway Contractor Payments from the Colorado Highway Department.
Life Insurance Sales from the Life Insurance Agency Management Sales Report.
Savings and Loan Net New Savings from Federal Home Loan Bank of Topeka.
National Park Visits from individual reporting areas.
Average Daily Highway Traffic from the Colorado Highway Department.
Air Passengers. Freight and Express from Stapleton International Airport Business Office.
Prices Received by Farmers from U.S. Department of Agriculture.

COLORADO TRENDS

The information contained in this section was provided by the Research and Analysis Unit of the Division of Employment and Training, Colorado Department of Labor and Employment (FY 77 Annual Planning Report).

Population and Labor Force Characteristics and Trends

Population and labor force have been increasing at high rates in Colorado for the last decade. The Bureau of the Census estimates population in the state at 2,534,000 as of July 1, 1975 representing an addition of 327,000 persons or an over 14 percent increase since April 1970. Population in the State, however, as measured by the Census Bureau slowed in 1975, increasing only 38,000 persons compared to an average of 72,000 persons per year growth during the period 1970-1974. Recent statistics indicate that population in the State grows by about 20,000 each year due to birth exceeding deaths by that amount. The remaining population growth in any given year is due to net in-migration. Between 1973 and 1974, in-migration was down by 25 percent and from 1974 to 1975 it was down approximately 13%.

During 1975, approximately 52 percent of those coming into the State were between the ages of 25-34 with slightly more males than females in-migrating. This age group is by far the most mobile in the population, totaling 41 percent of those emigrating.

Although the over 65 age group is the least mobile age group in-migration for males increased in 1975 over 1974.

As has been the case in most recent years over 80 percent of the population growth will occur in the front range area from Larimer and Weld counties on the north to Pueblo County on the south. Many mountain communities will continue to show relatively large population growth. In the next few years population will begin to increase as well in the rich coal and oil regions, primarily located in the northwest portion of the State. Approximately 12.5 percent of the counties in the State, however, will have declined in population since 1970. Almost all of these counties are rural counties with the exception of Denver County. 1970 Census data showed that 78.5 percent of Colorado's population resided in urban areas, up from 73.7 percent in 1960.

According to 1975 Census Estimate figures, the population increase in the balance of state area was 50,877. All of the other prime sponsor counties also had an increase in population, with the exception of Denver. While Denver lost 25,678 in population, the other prime sponsor counties gained 301,642, for a net gain in prime sponsor counties of 275,964 people.

The 1970 Census showed a minority population of 381,400 for Colorado representing 17.3 percent of total population compared to 11.0 percent in 1960. Individual minority groups and their percent of total population are: Black 3.0, Spanish Heritage 13.0, and all other races 1.3. Counties having a minority population above 30 percent include Alamosa, Archuleta, Conejos, Costilla, Huerfano, Las Animas, Otero, Pueblo, Rio Grande, and Saguache.

POPULATION AND PER CAPITA PERSONAL INCOME
COLORADO — PLANNING REGIONS — COUNTIES

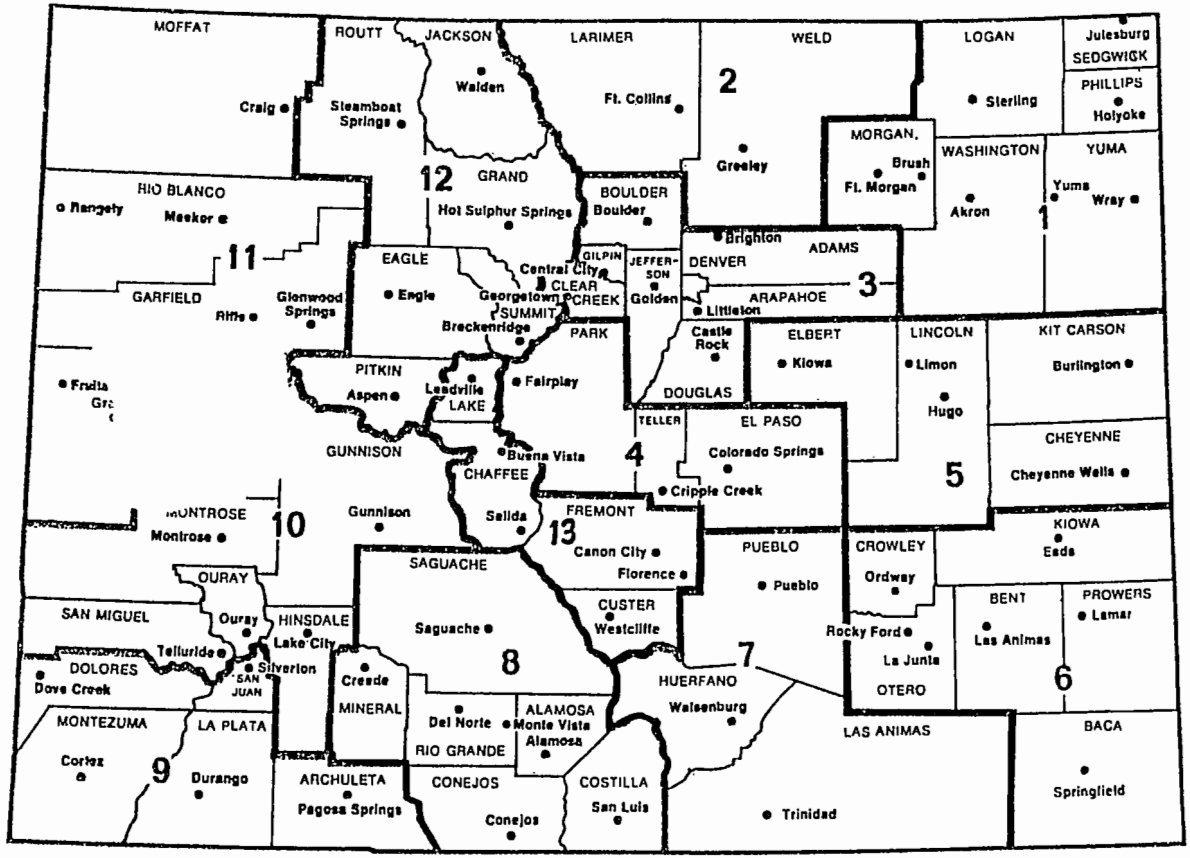
	POPULATION			PER CAPITA PERSONAL INCOME 2/		
	CENSUS 1970	ESTIMATED 1/ FY 1975	PERCENT CHANGE	1970	1974	PERCENT CHANGE
COLORADO	2,207,259	2,534,100	14.8	$ 3,855	$ 5,514	43.0
PLANNING REGION 1	60,587	62,000				
Logan	18,852	18,900	2.3	3,598	5,784	60.8
Morgan	20,105	21,400	6.4	3,648	5,307	45.5
Phillips	4,131	4,300	6.5	4,768	9,069	90.2
Sedgwick	3,405	3,300	-3.1	4,731	8,946	89.1
Washington	5,550	5,550	0	3,777	6,175	63.5
Yuma	8,544	8,600	.65	3,869	6,182	59.8
PLANNING REGION 2	179,197	228,600				
Larimer	89,900	120,900	34.5	3,223	4,597	42.6
Weld	89,297	107,700	20.6	3,111	5,130	64.9
PLANNING REGION 3	1,242,027	1,409,500				
Adams	185,789	214,800	15.6	3,604	5,154	43.0
Arapahoe	162,142	211,800	30.6	4,564	5,907	29.4
Boulder	131,889	166,500	26.2	4,093	5,246	28.2
Clear Creek	4,819	5,200	7.9	3,632	4,532	24.8
Denver	514,678	489,000	-5.0	4,514	7,104	57.4
Douglas	8,407	15,700	46.5	4,270	4,891	14.5
Gilpin	1,272	1,800	29.3	2,930	3,725	27.1
Jefferson	223,031	304,700	30.8	4,269	5,684	33.1
PLANNING REGION 4	241,473	295,500				
El Paso	235,972	286,100	21.2	3,791	4,885	28.8
Park	2,185	3,600	64.8	3,259	3,528	8.2
Teller	3,316	5,800	74.9	3,368	4,056	20.4
PLANNING REGION 5	18,665	20,100				
Cheyenne	2,396	2,200	-8.2	3,411	5,228	53.3
Elbert	3,903	5,400	38.4	2,487	3,198	28.6
Kit Carson	7,530	7,600	.9	3,752	7,347	95.8
Lincoln	4,836	4,900	1.3	3,343	4,808	43.8
PLANNING REGION 6	54,063	55,600				
Baca	5,674	5,700	.5	3,039	4,880	60.6
Bent	6,493	6,600	1.6	2,969	4,085	37.6
Crowley	3,086	3,200	3.7	2,646	3,772	42.6
Kiowa	2,029	2,100	3.5	5,216	7,225	38.5
Otero	23,523	24,300	3.3	2,944	4,292	45.8
Prowers	13,258	13,700	3.3	3,284	5,469	66.5
PLANNING REGION 7	140,572	147,500				
Huerfano	6,590	6,400	-2.9	2,207	3,128	41.7
Las Animas	15,744	15,700	- .3	2,576	3,555	38.0
Pueblo	118,238	125,400	6.1	3,276	4,867	48.6
PLANNING REGION 8	37,466	38,500				
Alamosa	11,422	12,100	5.9	2,593	4,115	58.7
Conejos	7,846	8,000	2.0	1,915	3,620	89.0
Costilla	3,091	3,100	.3	1,812	2,770	52.9
Mineral	786	800	1.8	3,403	3,702	8.8
Rio Grande	10,494	10,600	1.0	2,936	5,977	103.6
Saguache	3,827	3,900	1.9	2,279	4,213	84.9
PLANNING REGION 9	37,356	43,900				
Archuleta	2,733	3,100	13.4	2,696	3,778	40.1
Dolores	1,641	1,700	3.6	2,117	6,050	85.8
La Plata	19,199	23,300	21.4	2,718	4,022	48.0
Montezuma	12,952	15,000	15.8	2,420	3,904	61.3
San Juan	831	800	-3.7	2,812	3,534	25.7

POPULATION AND PER CAPITA PERSONAL INCOME
COLORADO — PLANNING REGIONS — COUNTIES

	POPULATION			PER CAPITA PERSONAL INCOME 2/		
	CENSUS 1970	ESTIMATED 1/ FY 1975	PERCENT CHANGE	1970	1974	PERCENT CHANGE
PLANNING REGION 10	44,927	51,200				
Delta	15,286	17,100	11.9	2,484	3,813	53.5
Gunnison	7,578	9,700	28.0	2,489	3,483	40.0
Hinsdale	202	400	98.0	2,088	2,824	35.2
Montrose	18,366	20,100	9.4	3,031	4,308	42.1
Ouray	1,546	1,800	16.4	3,351	4,876	45.5
San Miguel	1,949	2,100	7.7	2,620	3,271	24.8
PLANNING REGION 11	80,562	92,700				
Garfield	14,821	17,400	17.4	3,270	5,106	56.1
Mesa	54,374	61,900	13.8	3,190	4,799	50.4
Moffat	6,525	8,200	25.7	3,092	4,768	54.2
Rio Blanco	4,842	5,200	7.4	3,486	4,670	34.0
PLANNING REGION 12	28,858	42,200				
Eagle	7,498	10,000	33.4	3,445	4,550	32.1
Grand	4,107	6,200	51.0	2,887	3,657	26.7
Jackson	1,811	1,800	-.6	2,713	3,797	40.0
Pitkin	6,185	8,900	43.9	5,165	7,896	52.9
Routt	6,592	9,900	50.2	3,157	5,214	65.2
Summit	2,665	5,400	102.6	2,402	3,712	54.5
PLANNING REGION 13	41,506	46,800				
Chaffee	10,162	11,500	13.2	3,391	4,433	30.7
Custer	1,120	1,200	7.1	2,445	3,652	49.4
Fremont	21,942	26,000	18.5	2,849	3,851	40.1
Lake	8,282	8,100	-2.2	3,231	5,238	62.1

1/ 1975 Census Estimate
2/ Preliminary data provided by the Bureau of Economic Analysis, U.S. Department of Commerce

COLORADO PLANNING REGIONS



CENSUS POPULATION CHARACTERISTICS
COLORADO

	1960	1970	Percent Change
TOTAL POPULATION	1,753,947	2,207,259	25.8
A. White (including Spanish Heritage)	1,700,700	2,112,352	24.2
B. Black	39,992	66,411	66.1
Black Percent of Total Population	2.3	3.0	—
C. Spanish Heritage	157,173	286,467	82.3
Spanish Heritage Percent of Total Population	9.0	13.0	—
D. Other Races 1/	13,255	28,496	115.0
Other Races Percent of Total Population	0.8	1.3	—
E. 16 through 21	149,460 2/	261,896	75.2
Percent of Total Population	8.5	11.9	—
F. 22 through 44	531,186 2/	662,649	24.7
Percent of Total Population	30.3	30.0	—
G. 45 and over	478,095	594,254	24.3
Percent of Total Population	27.3	26.9	—
H. Male	870,467	1,089,377	25.1
I. Female	883,480	1,117,882	26.5
J. Urban Population	1,292,790	1,733,311	34.1
K. Rural Population	461,157	473,948	2.8
Percent Urban	73.7	78.5	—

1/ Includes Indian, Japanese, Chinese, Filipino, and all other races.
2/ Estimated from slightly different 1960 Census age breakouts.

Recent Trends In Unemployment

Unemployment continued to be a stubborn problem in the first five months of 1976 in Colorado averaging 71,400 persons or 6.2 percent of the labor force. This is only 100 persons and one-tenth of a percentage point lower than the same period in 1975. Unemployment in the two major industries adversely influenced by the economic downturn, manufacturing and contract construction, declined significantly. With employment growth increasing (as seen in the following exhibits) and unemployment insurance activities decreasing the number of unemployed and the rate will show greater improvement in the remaining months of 1977.

SEASONALLY ADJUSTED LABOR FORCE DATA*

COLORADO (in thousands)	Prelim FEB '77	Revised JAN '77	Revised FEB '76	Change From: Month Ago	Change From: Year Ago
Resident Civilian Labor Force	1,247.6	1,230.3	1,196.7	17.3	50.9
Unemployment	78.9	63.4	72.2	15.5	6.7
Unemployment Rate	6.3	5.2	6.0	—	—
Employment	1,168.7	1,166.9	1,124.5	1.8	44.2
DENVER-BOULDER LMA (in thousands)					
Resident Civilian Labor Force	738.9	729.4	704.1	9.5	34.8
Unemployment	47.9	38.1	44.5	9.8	3.4
Unemployment Rate	6.5	5.2	6.3	—	—
Employment	691.0	691.3	659.6	- 0.3	31.4
COLORADO SPRINGS SMSA					
Resident Civilian Labor Force	115,414	114,410	108,051	1,004	7,363
Unemployment	8,199	6,870	7,914	1,329	285
Unemployment Rate	7.1	6.0	7.3	—	—
Employment	107,215	107,540	100,137	- 325	7,078
PUEBLO SMSA					
Resident Civilian Labor Force	51,682	51,176	50,854	560	828
Unemployment	4,359	3,551	3,770	808	589
Unemployment Rate	8.4	6.9	7.4	—	—
Employment	47,323	47,625	47,084	- 302	239
FORT COLLINS SMSA					
Resident Civilian Labor Force	62,383	61,507	58,947	876	3,436
Unemployment	2,852	2,257	2,708	595	144
Unemployment Rate	4.6	3.7	4.6	—	—
Employment	59,531	59,250	56,239	281	3,292
GREELEY SMSA					
Resident Civilian Labor Force	58,822	57,761	56,956	1,061	1,866
Unemployment	2,780	2,162	2,225	618	555
Unemployment Rate	4.7	3.7	3.9	—	—
Employment	56,042	55,599	54,731	443	1,311

*To facilitate the evaluation of labor market developments, recurrent yearly movements have been isolated and removed by the X-11 Variant of the Census Method II Seasonal Adjustment Program.

Characteristics of the Insured Unemployed

The characteristics of the insured unemployed are gathered by means of a 20 percent sample of claimants who filed continued claims under the Colorado Employment Security Act during the survey week of each month. Persons unemployed and receiving unemployment benefits represent only a portion of the total number of unemployed. Excluded are agricultural workers; domestic servants; real estate; insurance; or security salesmen paid by commission.

Unemployment claims in 1975 strongly reflected the brunt of the national recession. Total survey week claims numbered 291,000 up 99 percent from 1974. Construction and manufacturing accounted for approximately 58 percent of all calims.

Duration of unemployment showed the greatest gains in the 20 weeks and over category. When comparing this excessive increase, 230 percent , consideration must be given to the fact that the recessive economy thrust into the unemployed category stable workers whose benefit periods warranted a full 26 weeks of monetary eligibility under the Colorado Employment Security Act. When the economy is enjoying high employment, those workers unemployed for 20 weeks or more, could have a less stable work history and therefore would not be monetarily eligible to collect unemployment insurance for a period of 20 weeks or more.

Consistent with past patterns, as industries reduce their employment levels, the younger workers are usually the first to be let go. The under 25 and 25-34 age groups showed greater increases than the older age groups in 1975. Of the approximately 100,000 claimants in the construction industry, 97,000 were male. This is indicative or the heavy employment of males in this industry. Male claimants in manufacturing represented 63 percent of total claimants in that industry.

CHARACTERISTICS OF THE INSURED UNEMPLOYED

Item	Colorado							
	Total Insured Unemployed				Male Insured Unemployed			
	1974	%	1975	%	1974	1974	1975	%
By Occupation								
Prof., Tech., Mgr.	24,712	17.2	47,315	16.2	N/A	N/A	34,337	16
Clerical	16,250	11.3	33,196	11.4	N/A	N/A	7,392	3
Sales	6,395	4.5	12,773	4.4	N/A	N/A	7,292	3
Services	10,477	7.3	19,982	6.9	N/A	N/A	8,003	3
Processing	6,009	4.2	11,185	3.8	N/A	N/A	8,456	4
Machine Trade	6,448	4.5	16,954	5.8	N/A	N/A	14,550	6
Batchwork	5,403	3.8	18,071	6.2	N/A	N/A	5,886	2
Structural Work	52,073	36.3	96,553	33.1	N/A	N/A	95,142	45
Miscellaneous	15,881	11.1	35,483	12.2	N/A	N/A	30,032	14
Total	143,648	100.2	291,512	100.0	N/A	N/A	211,100	100
By Industry								
Mining	1,950	1.3	3,117	1.1	1,789	1.7	2,834	1
Construction	59,918	40.9	100,423	34.4	54,888	51.9	97,041	47
Manufacturing	28,740	19.6	67,256	23.1	19,642	18.6	42.605	21
Trans. & Pub. Util.	5,879	4.0	13,049	4.5	4,079	3.9	10,156	5
Trade	22,001	15.0	46,639	16.0	11,549	10.9	26,504	13.
Finance	5,099	3.5	9,826	3.4	2,165	2.0	4,111	2
Services & (Farm)	17,876	12.2	38,582	13.2	8,312	7.9	19,659	9
Other	5,188	3.5	12,620	4.3	3,286	3.1	—	—
Total	146,651	100.0	291,512	100.0	105,710	100.0	202,910	100

Item	Colorado							
	Total Insured Unemployed				Male Insured Unemployed			
	1974	%	1975	%	1974	1974	1975	%
By Duration of Employ.								
1-2 weeks	46,854	32.6	91,455	31.3	36,245	34.3	67,303	31
3-4 weeks	24,775	17.2	42,758	14.7	19,274	18.2	32,214	15
5-8 weeks	32,108	22.4	58,288	20.0	23,698	22.4	42,352	20
9-14 weeks	24,420	17.0	53,637	18.4	16,726	15.8	38,694	18
15-19 weeks	8,970	6.2	23,822	8.2	5,812	5.5	17,018	8
20 & over	6,527	4.5	21,546	7.4	3,958	3.7	14,313	6
Total	143,654	100.0	291.506	100.0	105,713	100.0	211,894	100
By Age								
Under 25	31,095	21.7	68,350	23.4	22,628	21.5	48,250	22.8
25-34	48,264	33.6	105,180	36.1	37,049	35.0	79,064	37.3
35-44	25,248	17.6	48,979	16.8	17,950	17.0	34,013	16.0
45-54	21,301	14.8	39,959	13.7	15,139	14.3	28,656	13.5
55-64	16,291	11.3	26,727	9.2	11,878	11.2	20,041	9.5
65 and Over	1,460	1.0	2,264	.8	1,067	1.0	1,835	.9
Total	143,659	100.0	291,459	100.0	105,711	100.0	211,859	100.0

Occupational Outlook

It is expected that nearly 60 percent of job opportunities in Colorado during the period 1970- 1980 will be the result of increased employment levels; the other 40 percent will represent labor force separations which include death and retirements. Job opportunities created by employed persons changing jobs or occupations is not part of this consideration.

The following selected occupational projections are derived from estimated industry employment levels for 1980 applied to 1970 census-based industry staffing patterns for Colorado. Labor force separation rates by occupation were provided by the Bureau of Labor Statistics.

Total demand for an individual occupation excluding job changers can be estimated by adding the 1970-1980 employment level change to the total labor force separations for the ten-year period. For example, the total demand for typists 1970-1980 is projected to be 15,360 with 6,600 jobs occurring from increased employment levels and 8,760 occurring from replacement needs due to death and retirement.

Interpolation of occupational levels for interim years between 1970-1980 is hazardous. For example carpenters had lower employment levels in 1974 than in 1973 due to the temporary slowdown in contraction, but the projected level for 1980 is higher than the 1973 level. It also should be noted that these projections represent only the demand level; individual occupational supply will be dependent upon public and private training programs, population migration, occupational mobility, and demand changes in areas outside Colorado.

Copies of occupational projections 1970-1980 for Colorado and the Denver 5-county Area may be obtained from the Colorado Division of Employment, Research and Analysis Section.

OCCUPATIONAL TITLE	EMPLOYMENT 1970	EMPLOYMENT 1980	LABOR FORCE SEPARATIONS PER YEAR
TOTAL, ALL OCCUPATIONS	854790	1341360	32686
PROFESSIONAL, TECHNICAL, KINDRED	153590	255170	5594
ENGINEERS, TECHNICAL	16590	27500	252
ENGINEERS, PETROLEUM	350	760	5
LIFE AND PHYSICAL SCIENTISTS	4410	7990	87
GEOLOGISTS	1740	3730	32
MATHEMATICAL SPECIALISTS	530	970	17
ENGINEERS, SCIENCE TECHNICIANS	10580	20460	210
AGRI, BIOLOG TECH EXC HEALTH	390	800	19
ENGINEERING, SCIENCE TECH NEC	2540	6060	77
MEDICAL WORKERS, EXC TECH	20080	33040	1132
REGISTERED NURSES	11020	18630	775
THERAPISTS	1170	2440	77
VETERINARIANS	370	770	5
HEALTH TECHNOL AND TECH	3880	8090	289
CLINICAL LAB TECHNOL, TECH	1920	4040	138
OTHER TECHNOL, TECH	830	1710	45
TECHNICIANS, EXC HEALTH	3490	6360	75
OTHER TECHNICIANS EXC HEALTH	1050	2670	43
COMPUTER SPECIALISTS	3710	6460	69
SOCIAL SCIENTISTS	1430	3060	35
ECONOMISTS	710	1440	15
PSYCHOLOGISTS	530	1220	14
TEACHERS	43040	60520	1950
ELEMENTARY	17630	24360	1020
HEALTH SPECIALTIES TEACHERS	410	860	17
WRITERS, ARTISTS, ENTERTAINERS	9570	16900	353
OTHER PROFESSIONAL, TECHNICAL	30480	54150	1125
ACCOUNTANTS	9400	14600	318
CLERGYMEN	2500	5700	101
RELIGIOUS, EXC CLERGYMEN	590	1270	39
OPERATIONS, SYSTEMS RESEARCH	700	1530	14
VOCATIONAL, ED COUNSELORS	1860	3950	82
MANAGERS, OFFICIALS, PROPRIETORS	81490	139170	2751
BUYERS, SALES, LOAN MANAGERS	15300	26820	410
ADMINISTRATORS, PUB INSPECTORS	9610	15490	347
OTHER MANAGERS, OFFICALS, PROPS	53920	92330	1994
RAILROAD CONDUCTORS	370	790	19
SALES WORKERS	65750	105310	2784
SALES CLERKS, RETAIL TRADE	24460	40200	1497
CLERICAL WORKERS	159910	261350	8879
STENOGRAPHERS, TYPISTS, SECRE	46590	79400	3539
SECRETARIES, OTHER	31810	56680	2440
TYPISTS	11350	17950	876
OFFICE MACHINE OPERATORS	6770	9900	381
COMPUTER, PERIPHERAL EQUIP	1540	3090	47
OTHER CLERICAL WORKERS	90420	145680	4959
BOOKKEEPERS	19490	29410	112
CASHIERS	9310	15050	619
TEACHERS AIDES, EXC MONITORS	2070	4830	130
CRAFTSMEN, FOREMEN, KINDRED	106600	168580	2320
CONSTRUCTION CRAFTSMEN	31110	53570	750
CARPENTERS	10260	17290	298
CEMENT AND CONCRETE FINISHERS	770	1580	15
ROOFERS AND SLATERS	720	1560	11

OCCUPATIONAL TITLE	EMPLOYMENT 1970	EMPLOYMENT 1980	LABOR FORCE SEPARATIONS PER YEAR
METALWORKING CRAFTSMEN EXC MECH	7750	11380	139
MECHANICS, REPAIRMEN, INSTALLERS	26520	40210	512
AIR COND, HEATING, REFRIG	940	2160	28
DATA PROCESSING MACH REPAIRMEN	380	800	6
PRINTING TRADE CRAFTSMEN	4160	6010	116
TRANSPORTATION, PUB UTIL CRAFT	5550	9220	88
LOCOMOTIVE ENGINEERS	630	1310	36
OTHER CRAFTSMEN, KINDRED WORKERS	12770	19250	403
OPERATIVES	101180	153570	2541
SEMISKILLED METALWORKING	8210	13280	179
SEMISKILLED TEXTILE	100	160	3
SEMISKILLED PACKING, INSPECTING	7000	11440	288
OTHER OPERATIVES, EXC TRANSPORT	54770	81800	1498
DRY WALL INSTALLERS, LATHERS	900	1950	9
TRANSPORT EQUIPMENT OPERATIVES	31110	46890	573
TRUCK DRIVERS	15710	21440	246
SERVICE WORKERS	118490	174250	6114
CLEANING SERVICE WORKERS	23520	38160	1145
JANITORS AND SEXTONS	16080	27470	702
FOOD SERVICE WORKERS	40420	47600	1888
HEALTH SERVICE WORKERS	14140	24490	1073
HEALTH AIDES, EXC NURSING	1680	3450	144
NURSES AIDES, ORDERLIES	8420	13670	606
PERSONAL SERVICE WORKERS	15070	23220	983
PROTECTIVE SERVICE WORKERS	9180	13630	219
PRIVATE HOUSEHOLD WORKERS	8940	16540	806
LABORERS, EXC FARM	34630	51600	615
FARMERS AND FARM WORKERS	33140	32360	1088
FARMERS AND FARM MANAGERS	20210	20430	800
FARM MANAGERS	1230	2460	48
FARM LABORERS, FARM FOREMEN	12930	11940	288

Selected Occupational Information

Occupation Code		Colorado Active Applc.	Openings Rec'd	Unfilled 30 days or more	Wage 1/ Rate
001	Architecture	122	30	1	N/A
003	Electrical Engineering	417	151	13	5.51
005	Civil engineering	152	118	1	4.42
007	Mechanical engineering	277	181	6	5.11
012	Industrial engineering	150	71	8	6.73
017	Drafting and related work	112	69	1	3.73
018	Surveying and related work	224	203	3	3.49
020	Mathematics	197	122	21	6.22
029	Math. and phy. sci., n.e.c.	119	40	2	3.45
045	Psychology	436	131	14	4.05
075	Nursing	129	160	38	4.54
078	Medical & dental tech.	200	110	10	4.07
079	Medicine & health, n.e.c.	491	247	22	3.13
091	Secondary school education	260	64	5	4.97
092	Pri. school & kind. educ.	314	58	2	3.15
099	Education, n.e.c.	224	139	9	3.61
141	Commercial art	141	27	0	N/A
142	Designing	124	26	0	N/A
143	Photography	135	24	0	N/A
152	Music	169	22	0	4.11
160	Accounting and auditing	358	109	4	5.21
162	Purchasing management	168	34	1	5.14
163	Sales and dist. mgmt.	195	35	3	4.45
165	Public relations mgmt.	115	18	0	N/A
166	Personnel & training admin.	179	97	4	4.88
168	Inspt. & invest., managerial & pub. service	110	28	0	N/A
169	Admin. specialties, n.e.c.	831	272	7	4.12
182	Construction mgmt.	158	19	0	N/A
183	Manuf. industry mgmt.	109	34	2	5.39
185	Whsle. & ret. tr. mgmt.	476	114	1	3.40
186	Fin., ins., & real est. mgmt.	394	176	5	2.95
187	Service Industry mgmt.	665	157	6	3.60
189	Misc. managerial work, n.e.c.	535	207	1	3.35
195	Social & welfare work	624	240	14	3.72
196	Airplane piloting & nav.	111	3	0	N/A
201	Secretarial work	1,399	1,459	23	3.19
203	Typing	110	276	1	2.86
206	Filing	227	172	0	2.45
209	Steno., typ., fil., & related work, n.e.c.	1,907	1,683	310	4.87
210	Bookkeeping	816	744	18	3.02
211	Cashiering	1,019	510	4	2.38
212	Teller service	138	102	0	2.56
213	Automatic data processing	435	391	7	3.01
219	Computing & acct. rec., n.e.c.	2,348	1,691	28	2.76
222	Cler. work, shipping & recv.	345	161	2	2.70
223	Stock checking & related work	831	615	11	2.63
231	Mail sorting, stamp., rec., routing, & related work	147	92	1	2.65

Occupation Code	Selected Occupational Information — Colorado: Active Applc.	Openings Rec'd	Unfilled 30 days or more	Wage 1/ Rate
235 Telephone work	242	162	1	2.59
237 Recp. & info. disp. work	705	499	8	2.59
249 Misc. clerical work, n.e.c.	228	372	44	2.85
250 Saleswork, real est. & ins.	132	219	57	3.77
263 Saleswork, text., textile prod., and apparel	150	227	2	2.38
280 Saleswork, trans. equip.	125	68	0	N/A
289 Saleswork, commod., n.e.c.	1,109	924	123	2.57
290 Sales clerking	1,170	1,002	15	2.32
292 Route work	173	216	1	3.23
299 Misc. mdse. work, n.e.c.	745	466	14	2.97
301 Day work	800	886	14	2.57
304 Housemen and yard work	116	2,828	12	5.48
306 Housework. domestic	670	652	14	2.15
307 Nursemaid work	263	402	8	N/A
311 Food serving	2,703	2,484	28	1.70
312 Bartending	631	250	6	2.50
313 Cooking, lg. hotels & rest.	999	868	16	2.71
314 Cooking, sm. hotels & rest.	227	218	2	2.41
315 Misc. cooking, exc. domestics	120	213	4	2.80
316 Meatcutting, exc. in slaght'g and packing houses	155	107	3	3.35
317 Misc. food & bev. prep.	154	218	6	2.36
318 Kitchen work, n.e.c.	847	1,697	13	2.15
323 Maid & rel. ser., htls. rest., & rel. estabmts.	600	1,160	37	2.31
332 Beautician services	200	52	3	N/A
352 Hostess & steward ser., n.e.c.	186	18	0	N/A
355 Attnd. wk., hosp., morgues, & rel. health	1,197	483	9	2.35
359 Misc. pers. ser., n.e.c.	201	152	3	2.37
261 Laundering service	136	291	0	2.30
372 Guard & rel. services	395	402	10	2.79
375 Pol. & rel. wk., pub. ser.	138	64	0	3.20
381 Cleaning & rel. services	632	1,104	4	2.47
382 Janitorial service	904	975	22	2.61
406 Horticultural spec. wk.	137	81	2	2.19
407 Gardening & groundskpg.	505	557	5	2.61
413 Livestock farming	186	43	0	2.14
421 General farming	463	155	23	2.22
509 Metal processing, n.e.c.	174	85	0	4.58
525 Slaght'g, brk., curing & rel work	234	92	1	3.21
526 Cooking & baking, n.e.c.	134	68	3	2.67
529 Proc. fd. & rel. prod. n.e.c.	394	713	1	2.31
589 Proc., leat. & tex., n.e.c.	313	421	1	2.55
600 Mach. & related work	350	196	14	3.94
609 Metal mach., n.e.c.	219	95	2	3.23
616 Fab. mach. work	241	54	0	3.03
620 Mot. veh. & eng. equip. rep.	1,389	832	23	3.46
621 Aircraft repairing	152	40	0	N/A
625 Eng., pow. trans., & rel. equip. repairing	128	76	7	4.47

Selected Occupational Information

Occupation Code		Colorado Active Applc.	Openings Rec'd	Unfilled 30 days or more	Wage 1/ Rate
638	Misc. mach. instal. & rep.	170	128	1	4.10
651	Printing press work	154	80	3	3.53
706	Met. ut. assy. & adj., n.e.c.	695	1,268	7	2.93
726	Assy. & rep. of elec. comp. & access., n.e.c.	361	148	1	2.55
729	Assy. & rep. of elec. equip., n.e.c.	160	166	9	2.30
739	Fab. & rep. of prod. made from asst. mat., n.e.c.	124	90	0	2.30
787	Mach. sewing, nongarment	212	217	8	2.35
801	Fit., bolt., scrw., & rel. wk.	144	63	0	N/A
804	Sheet metal work	217	130	1	4.00
806	Trans. equip. assy. & rel. wk.	123	90	4	3.61
807	Body wk., trans. equip.	198	131	4	3.32
810	Arc welding	392	155	3	3.72
812	Comb. arc & gas welding	352	167	5	4.17
822	Wire comm., det., & sig. equip. assy., install, & rep.	154	19	0	3.30
824	Lgt. equip. & bldg. wiring assy., install, & rep. n.e.c.	352	134	6	5.89
828	Elec. & elec. prod. fab., install., & rep., n.e.c.	196	60	8	4.96
829	Assy., install., & rep. of elec. prod., n.e.c.	146	52	4	4.08
840	Const. & maint. patg. & rel. wk.	528	348	2	3.41
842	Plast. & related work	221	72	0	4.75
844	Cem. & con. fin. & rel. wk.	332	159	2	4.84
850	Excav., grd., & rel. wk.	145	69	1	4.36
859	Excav., grd., & rel. wk. n.e.c.	794	123	3	4.72
860	Carpentry & related work	2,369	1,357	48	3.83
861	Brk. & st. mas. & tile set.	212	92	2	3.53
862	Plb. gas fit. st. fit., & related work	501	365	2	3.72
866	Roofing & related work	225	295	5	3.51
869	Misc. const. work, n.e.c.	4,128	4,578	22	3.27
899	Misc. struc. work, n.e.c.	639	785	7	2.99
904	Trailer-truck driving	351	109	2	2.65
905	Heavy truck driving	1,561	1,394	10	3.18
906	Light truck driving	996	437	5	2.88
909	Motor frt. trans., n.e.c.	114	2,886	41	3.90
913	Pass. trans., n.e.c.	198	226	3	2.81
915	Pk lot & rel. ser. work	588	769	8	2.39
919	Misc. trans., work, n.e.c.	285	886	3	2.58
920	Packaging	556	371	6	2.58
	Mat. moving & storing, n.e.c.	1,678	1,344	11	2.70
	Pack. & mat. handling, n.e.c.	1,644	5,690	46	2.69
930	Boring, drl., cut., & rel. wk.	257	171	4	5.15
939	Ext. of minerals, n.e.c.	553	778	23	5.06

1/ Wage Rate - ESARS Occupational Wage Survey for Region VIII
2/ Source: Applicant and Job Openings - ESARS table 96
July '75 - March '76

N/A - not available

Persons Needing Manpower Services

For FY 1977, the Employment and Training Administration (ETA) of the Department of Labor has recommended a new series of concepts and methodologies based on the 1970 Census to develop statistics of the economically disadvantaged, employed part-time for economic reasons, welfare recipients and the unemployed Vietnam-era aged 20-34 years.

An economically disadvantaged person is one whose annual income is below the Federally developed poverty level, i.e. $5,500 for a family of four.

A part-time employed person for economic reasons is defined as one who desires full-time work, but cannot find regualr employment because of lack of skills, lack of job opportunities, age (under 21 or over 45), and/or family care barriers.

Welfare recipients over age 14 are those persons receiving public assistance when their total income is below poverty or they have no income at all.

Unemployed Vietnam-era veterans are those who served between August 4, 1964, and May 7, 1975.

The Manpower Data Summary tables Annual Average Employment Status Tables and Selected Employment Service Statistics have been prepared for the state and for each prime sponsor jurisdiction as a guide to the number of people needing employment related manpower services. These summary tables include projections for Fy 1977 population, labor force, employment, unemployment and the number of economically disadvantaged, part-time workers, welfare recipients and unemployed Vietnam-era veterans. These statistics were developed with 1970 Census data and other best available information.

These tables reflect some of the target groups most in need of manpower development. The male minority reflects an annual average unemployment rate of 14.4 percent in 1975. The Spanish surnamed male has an unemployment rate of 11.3 percent. According to the ETA/Census use methodology, approximately 200,000 people in the state are economically disadvantaged, of which 23 percent are minorities. The Employment Security Automated Reporting System (ESARS) indicates that 32 percent of their new applicants and renewals, during the period March 1, 1975 through July 31, 1976 are economically disadvantaged and 22 percent are minorities. Approximately 40 percent of the minority and economically disadvantaged applicants have between 8 through 11 years of education and about 37 percent of these two groups are between the ages of 25 through 39.

Therefore, it can be noted that the barriers to employment in Colorado are minority status, lack of education, age, lack of skills, occupational skills that reflect a large labor pool and family care problems.

1975 Preliminary Annual Average
EMPLOYMENT STATUS BY RACE AND SEX
Colorado

Race and Sex	Civilian Labor Force	Employed	Unemployed	Unemployment Rate	Percent Distribution		
					Labor Force	Employed	Unemployed
BOTH SEXES							
Total	1,154,300	1,080,000	74,300	6.4	100.0	100.0	100.0
White	1,112,100	1,042,100	70,000	6.3	96.3	96.5	94.2
Black	30,800	27,600	3,200	10.4	2.7	2.6	4.3
Spanish Heritage 1/	122,600	109,700	12,900	10.5	10.6	10.2	17.4
All Other Races	11,400	10,300	1,100	9.6	1,0	1.0	1.5
Total Minority 2/	164,800	147,600	17,200	10.4	14.3	13.7	23.1
MALE							
Total	710,300	667,500	42.800	6.0	61.5	61.8	57.6
White	687,400	646,900	40,500	5.9	59.6	59.9	54.5
Black	16,200	14,500	1,700	10.5	1.4	1.3	2.3
Spanish Heritage 1/	80,100	71,700	8,400	10.5	6.9	6.6	11.3
All Other Races	6,700	6,100	600	9.0	0.6	0.6	0.8
Total Minority 2/	103,000	92,300	10,700	10.4	8.9	8.5	14.4
FEMALE							
Total	444,000	412,500	31,500	7.1	38.5	38.2	42.4
Percent of Both Sexes	38.5	38.2	42.4	xxx	xxx	xxx	xxx
White	424,700	395,200	29,500	6.9	36.8	36.6	39.7
Black	14,600	13,100	1,500	10.3	1.3	1.2	2.0
Spanish Heritage 1/	42,500	38,000	4,500	10.6	3.7	3.5	6.1
All Other Races	4,700	4,200	500	10.6	0.4	0.4	0.7
Total Minority 2/	61,800	55,300	6,500	10.5	5.4	5.1	8.7

1/ The Spanish Heritage data is included in the White and Total Minority data.
2/ Sum of Black, Spanish Heritage, and All Other Races.
Race and sex detail may not add due to calculations of ratios and rounding.

COLORADO LABOR FORCE ESTIMATES BENCHMARKED TO CURRENT POPULATION SURVEY

Introduction of Statewide Survey:

Due to an overall expansion in coverage the national Current Population Survey (CPS) is now being used as an annual benchmark for all Colorado labor force estimates. The revisions in the originally published data series caused by this benchmarking process will affect estimates back to January 1970 for every Colorado area except the Denver-Boulder LMA. The Denver area has been benchmarked to the CPS for the past several years and thus revisions prior to 1974 are minimal.

Since 1940 the household survey procedure known as the CPS has been utilized to compile labor force statistics on the national level. At the present time some 55,000 housing units around the country are assigned for interview each month in this survey. In contrast, labor force data on the local level is derived through a federally developed procedure involving the use of locally available information from administrative data systems and derived statistical relationships. It is widely believed that the household survey technique utilized at the national level is much more consistent and reliable than the mathematical building block approach used locally.

In 1974 the federal Bureau of Labor Statistics (BLS) made provisions for the benchmarking of local labor force data to the CPS in those areas in which the CPS sample was of sufficient size to produce a locally valid annual average. In Colorado this meant that employment and unemployment estimates for the Denver-Boulder LMA began to be benchmarked annually to the CPS, while figures for the balance of the State area were computed in the historical manner without benchmarking.

State Methodology and BLS Methodology

At the time of the 1975 CPS benchmark for the Denver-Boulder LMA, which occurred in early 1976, the BLS also instituted a program of adjusting labor force data in non-CPS areas of the country to broad national CPS totals. This had the net affect of lowering unemployment rates in all Colorado areas outside Metropolitan Denver for 1975 and 1976 at the same time that the regular CPS benchmarking process in the Denver-Boulder LMA drastically raised that area's unemployment. (For a more in-depth discussion of these events, see the April 1976 issue of the "Colorado Manpower Review.")

During this period the Research and Analysis (R & A) unit of the Colorado Division of Employment and Training, after much study, felt that the BLS mandated adjustments to the Colorado labor force series did not take into account Colorado's unique situation of being partially a CPS area and partially a non-CPS area. R & A decided to produce, in addition to the data calculated utilizing all the BLS mandated adjustments for federal program purposes, another labor force series for all Colorado areas which could be used for economic analysis. Thus came about the division of "State methodology" and "BLS methodology." In the State methodology series for economic analysis, the BLS method of extrapolating the 1975 CPS level into 1976 for the Denver area was modified to allow for changing economic conditions. The result of utilizing this variable extrapolator was an overall lowering of the unemployment rate in the Denver Metropolitan area during 1976, as compared to the rate calculated under strict BLS methodology. For areas outside the Denver-Boulder LMA, the State methodology series disregarded the procedure of adjusting employment and unemployment data in non-CPS areas to meet broad national CPS levels. The result was a higher unemployment rate for these "balance of the State" areas than that recorded by the BLS methodology. It should be re-emphasized that the distribution of federal monies to high unemployment areas was based on the federally mandated BLS series of labor force data.

The recent release of 1976 CPS data for both the Denver-Boulder LMA and the State of Colorado as a whole indicates that the position adopted by the R & A staff during 1976 was justified. Revisions introduced from the 1976 CPS benchmark have substantially lowered the estimated unemployment rate in the Denver metropolitan area even below the level produced by the State methodology. In areas outside Denver, the expanded 1976 CPS indicates that unemployment was being significantly underestimated by the strict BLS methodology and also to a lesser extent by State methodology. The net result of the 1976 CPS benchmark is statewide 1976 unemployment rates that are very similar to the ones originally published under both State and BLS methodologies. Large adjustments, however, are made from the BLS methodology in the distribution of unemployment between the Denver-Boulder LMA and the balance of the State.

According to the current CPS benchmark, the annual average unemployment rate for the State of Colorado was 5.9 percent in 1976. Both State and BLS methodologies indicated a 1976 Colorado unemployment rate of 6.0 percent. In the Denver-Boulder LMA, however, the 1976 CPS derived unemployment rate was 6.1 percent, compared to 6.6 under State methodology and 6.8 percent under the BLS mandated procedure. In the balance of the State, CPS figures showed a 1976 annual average unemployment rate of 5.6 percent, while computed under State methodology the 1976 rate was 5.2 percent and under BLS methodology the 1976 rate was 5.2 percent and under BLS methodology it was 4.8 percent.

State Methodology Series Discontinued:

As previously indicated, the adjustments in Colorado unemployment rates which have come about as a result of expanded CPS measurements are in line with the anticipations of the Research and Analysis staff. They indicate that the variations from the strict BLS procedures which were encompassed in the State methodology series of labor force calculation were, indeed, a step in the right direction. However, with the introduction of statewide CPS benchmarking, the contradictory treatment of labor force computations in Colorado's non-CPS areas which occurred under mandated BLS procedures has been abolished. It is now felt that the State methodology concept of labor force calculation has served its purpose and the primary cause of its inception has disappeared. Since all Colorado labor areas are now benchmarked directly to the CPS, there will no longer be published separate labor force estimates computed under State and BLS methodologies. Labor force statistics computed under BLS/CPS methodology will be put forth as both a tool for economic analysis and a requirement for federal program eligiblity purposes. Hopefully, this approach will also result in less confusion concerning employment and unemployment data.

This is not to say that R & A analysis of the computational processes and the validity of Colorado labor force estimates will cease. Even under that current system of statewide benchmarking to CPS levels, there is room for questioning and discussion.

Reliability of Current CPS Data:

In the past, the unemployment side of labor force estimating has usually received the most emphasis. The level of unemployment and the unemployment rate has tended to be the overriding concern of people interested in the validity of statistics for Colorado or any other area. It should be realized, however, that the calculation of employment is also important and changes in the rate of job growth can be very meaningful in the analysis of economic trends.

According to CPS figures, in 1976 Colorado showed a gain of some 72,000 jobs over the prior year. That would be the second highest annual employment growth for the State since the compilation of labor force data began -- in the only higher instance employment grew by 93,000 during the 1972-1973 period according to the CPS. 1976 was definitely a year of recovery for the Colorado economy, but an expansion of 72,000 people on the employment side does not appear to be justified at this point.

This magnitude of job growth has, so far, not materialized in any other data systems which reflect on the total employment level. The Current Employment Statistics (CES) program data on nonagricultural wage and salary employment by place of work, which is derived from a monthly mail sample survey of employers and appears regularly in the Manpower Review, indicates job growth between 1975 and 1976 in Colorado of just over 27,000. Admittedly, this series is not equivalent to the total employment calculation, and due to the benchmark timing of the CES program, some growth occurring in employment is not registered. The currently published CES data on place of work, nonagricultural wage and salary employment is based on a March 1974 benchmark primarily with an Employment Service report known as the ES-202. The ES-202 is a compilation of confidential reports on employment and earnings which each eligible employer is required to file with the Colorado Division of Employment and Training under the State's Employment Security Act. Employment attributed to firms which have come into being during the 1976 period of economic growth in Colorado would be unrepresented in CES data based on the March 1974 benchmark.

Preliminary data from the ES-202 through the third quarter of 1976 registers approximately 37,000 new jobs in Colorado over the same period in 1975. There are certain portions of nonagriculatual wage and salary employment that are not included in this report--primarily related to government--but that still leaves a good deal of CPS registered growth unaccounted for.

Neither of the two above-mentioned series on employment (the CES program or the ES-202) can be utilized as a direct substitute for a total employment estimate. Both are based on the measurement of jobs by place of work, rather than the employment of people by place of residence definition, which determines a total area employment. Conceptually, however, the number of jobs by place of work should tend to be higher than the number of people employed by residence, and that would serve to widen the gap between the CPS employment growth rate and that indicated by these data series. On the whole, when allowances are made for the employment areas not covered and the conceptual differences, the CES program and the ES-202 do not support the growth of 72,000 new jobs in Colorado indicated by the 1976 Current Population Survey.

Questions on the reliability of the CPS to serve as a benchmark for local labor force estimates are not unique to the Colorado situation. Nationally 23 states were benchmarked to the CPS for the first time this year. A preliminary review of 1976 CPS data for these areas indicates significant revisions from originally calculated data in may states. In some cases, the number of unemployed, as measured by payments for unemployment compensation, actually exceeded the CPS estimate of total unemployment. This state of affairs prompted the Research and Statistics Committee of the Interstate Conference of Employment Security Agencies to express "strong misgivings and serious doubts concerning the 1976 revisions proposed by BLS to state and local area unemployment statistics necessitated by adjustments to the Current Population Survey" in their December 1976 meeting.

The R & A staff will continue to monitor and analyze the concepts utilized in the Calculation of Colorado labor force statistics. For at least the immediate future, however, all Colorado area unemployment rates utilized by this publication for economic analysis will be based on methodology which strictly follows the guidelines established by the federal Bureau of Labor Statistics.

State of Colorado
Division of Employment
Research and Analysis

County Labor Force Estimates—Colorado
Average Monthly Labor Force for
January '75—December '75 CPS Benchmark
3-25-77

AREA	TOTAL LABOR FORCE	TOTAL EMPLOY	NONAG W&S EMPLOY	ALL OTHER EMP	AG EMP	TOTAL UN EMP	% UN EMP
Alamosa	5422	5170	4197	376	597	252	4.6
Archuleta	1054	936	673	137	126	118	11.2
Baca	2595	2543	1405	282	856	52	2
Bent	2218	2113	1451	135	527	105	4.7
Chaffee	4977	4685	4024	507	154	292	5.9
Cheyenne	1144	1104	558	116	430	40	3.5
Co. Spgs. SMSA1/	103826	95169	85046	8813	1310	8657	8.3
Conejos	2996	2777	1861	317	599	219	7.3
Costilla	1072	977	710	74	193	95	8.9
Crowley	1156	1100	736	92	272	56	4.8
Custer	498	485	258	20	207	13	2.6
Delta	6212	5736	3774	682	1280	476	7.7
Den-Bldr LMA2/	679000	630000	574711	46922	8367	49000	7.3
Dolores	572	537	379	27	131	35	6.1
Eagle	5428	4857	4228	341	288	571	10.5
Elbert	2042	1909	946	230	733	133	6.5
Fremont	8618	7984	6634	1051	299	634	7.4
Garfield	9278	8718	7032	1038	648	560	6
Grand	3812	3656	2782	668	206	156	4.1
Gunnison	3758	3492	2883	317	292	266	7.1
Hinsdale	116	110	65	38	7	6	5.2
Huerfano	2071	1884	1424	208	252	187	9
Jackson	854	817	589	88	140	37	4.3
Kiowa	877	833	414	31	388	44	5
Kit Carson	3668	3581	1927	467	1187	87	2.4
Lake	3710	3446	3232	194	20	264	7.1
La Plata	10806	8756	7982	1085	789	950	8.8
Larimer	55948	53095	45353	5048	2694	2853	5.1
Las Animas	5204	4843	3773	488	582	361	6.9
Lincoln	2192	2109	1283	284	542	83	3.8
Logan	8223	7944	5768	800	1376	279	3.4
Mesa	29073	27404	22740	2771	1893	1669	5.7
Mineral	458	442	424	17	1	16	3.5
Moffat	4052	3749	2682	613	454	303	7.5
Montezuma	5507	5046	4181	404	461	461	8.4
Montrose	8374	7801	5827	876	1098	573	6.8
Morgan	9463	8863	5770	947	2146	600	6.3
Otero	9607	8988	7042	1050	896	619	6.4
Ouray	873	830	592	75	163	43	4.9
Park	1008	915	613	159	143	93	9.2
Phillips	1867	1826	1016	160	650	41	2.2
Pitkin	4615	4132	3325	592	215	483	10.5
Prowers	5943	5708	3929	620	1159	235	4
Pueblo SMSA3/	48927	45379	41483	2865	1031	3548	7.3
Rio Blanco	1940	1866	1225	268	373	74	3.8
Rio Grande	5238	4930	3522	564	844	308	5.9
Routt	6268	5769	4664	702	403	499	8
Saguache	1997	1873	1128	152	593	124	6.2
San Juan	460	434	398	36	0	26	5.7
San Miguel	1221	1082	897	114	71	139	11.4
Sedgwick	1573	1482	725	228	529	91	5.8
Summit	4684	4278	3705	503	70	406	8.7
Washington	2391	2331	1061	190	1080	60	2.5
Weld	53936	51291	41108	3761	6422	2645	4.9
Yuma	4187	4122	2108	546	1468	65	1.6
State Total 4/	1153000	1073000	936262	89088	47650	80000	6.9

State of Colorado
Division of Employment
Research and Analysis

County Labor Force Estimates—Colorado
Average Monthly Labor Force for
January '76—December '76 CPS Benchmark
3-4-77 CC

AREA	TOTAL LABOR FORCE	TOTAL EMPLOY	NONAG W&S EMPLOY	ALL OTHER EMP	AG EMP	TOTAL UN EMP	% UN EMP
Alamosa	5404	5137	4212	359	566	267	4.9
Archuleta	1003	913	665	129	119	90	9
Baca	2517	2475	1398	266	811	42	1.7
Bent	2173	2088	1461	128	499	85	3.9
Chaffee	4742	4449	3842	461	146	293	6.2
Cheyenne	1078	1051	538	106	407	27	2.5
Co. Spgs. SMSA1/	109916	102648	92374	9035	1239	7268	6.6
Conejos	2976	2732	1866	298	568	244	8.2
Costilla	1147	1066	805	78	183	81	7.1
Crowley	1126	1076	731	87	258	50	4.4
Custer	450	441	229	15	197	9	2
Delta	6396	5942	4032	697	1213	454	7.1
Den-Bldr LMA2/	717999	674999	619653	46838	8508	43000	6.1
Dolores	560	524	375	25	124	36	6.4
Eagle	6755	6153	5460	420	273	602	8.9
Elbert	2047	1924	1001	228	695	123	6
Fremont	8541	7939	6647	1008	284	602	7
Garfield	9253	8704	7090	1000	614	549	5.9
Grand	4594	4418	3434	789	195	176	3.8
Gunnison	4004	3762	3157	329	276	242	6
Hinsdale	75	73	40	26	7	2	2.7
Huerfano	2003	1836	1402	195	239	167	8.3
Jackson	703	671	471	67	133	32	4.6
Kiowa	819	799	403	28	368	20	2.4
Kit Carson	3560	3470	1907	439	1124	90	2.5
Lake	3933	3625	3410	196	19	308	7.8
La Plata	10471	9755	7978	1030	747	716	6.8
Larimer	61092	58537	50711	5298	2529	2555	4.2
Las Animas	5267	4936	3902	482	552	331	6.3
Lincoln	2156	2097	1308	276	513	59	2.7
Logan	8445	8155	6053	799	1303	290	3.4
Mesa	30189	28662	24102	2769	1791	1527	5.1
Mineral	465	437	420	16	1	28	6
Moffat	4128	3828	2785	613	430	300	7.3
Montezuma	5545	5082	4256	390	436	463	8.3
Montrose	8364	7785	5903	842	1040	579	6.9
Morgan	9290	8885	5924	929	2032	405	4.4
Otero	9397	8907	7054	1004	849	490	5.2
Ouray	685	636	430	51	155	49	7.2
Park	844	784	519	129	136	60	7.1
Phillips	1768	1729	969	145	615	39	2.2
Pitkin	5686	5265	4310	751	204	421	7.4
Prowers	6072	5826	4111	617	1098	246	4.1
Pueblo SMSA3/	51748	48278	44417	2903	958	3470	6.7
Rio Blanco	1754	1688	1103	231	354	66	3.8
Rio Grande	5243	4939	3593	547	799	304	5.8
Routt	7517	6969	5764	823	382	548	7.3
Saguache	1947	1820	1119	139	562	127	6.5
San Juan	458	431	397	34	0	27	5.9
San Miguel	1394	1236	1045	124	67	158	11.3
Sedgwick	1440	1368	667	200	501	72	5
Summit	6994	6543	5775	722	66	451	6.4
Washington	2351	2280	1074	183	1023	71	3
Weld	57661	55441	45456	3909	6076	2220	3.9
Yuma	3858	3787	1921	474	1392	71	1.8
State Total 4/	1216000	1145000	1009647	89678	45675	71000	5.9

All estimates made in accordance with methodology provided by the U.S. Department of Labor, Bureau of Labor Statistics.
1/ Includes El Paso and Teller Counties
2/ Includes Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Gilpin, and Jefferson Counties
3/ Includes Pueblo County
4/ Individual areas may not add to state total due to rounding

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area. PS0800504 ADAMS COUNTY (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	104,501	96,423	8078	7.7
February	76 02	104,681	97,645	7036	6.7
March	76 03	107,392	99,644	7748	7.2
April	76 04	108,590	101,697	6893	6.3
May	76 05	110,132	104,074	6058	5.5
June	76 06	112,050	104,853	7197	6.4
July	76 07	111,419	103,986	7433	6.7
August	76 08	110,484	103,620	6864	6.2
September	76 09	110,330	103,968	6362	5.8
October	76 10	110,476	104,446	6030	5.5
November	76 11	110,924	103,976	6948	6.3
December	76 12	110,287	103,697	6590	6.0
Annual Average	76 13	109,272	102,336	6936	6.3

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0801007 ARAPAHOE COUNTY (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE

Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	99,896	93,689	6207	6.2
February	76 02	100,166	94,877	5289	5.3
March	76 03	102,712	96,819	5893	5.7
April	76 04	103,619	98,813	4806	4.6
May	76 05	105,763	101,123	4640	4.4
June	76 06	107,477	101,879	5598	5.2
July	76 07	106,828	101,038	5790	5.4
August	76 08	105,988	100,682	5306	5.0
September	76 09	106,136	101,019	5117	4.8
October	76 10	106,747	101,485	4662	4.4
November	76 11	106,715	101,028	5687	5.3
December	76 12	106,055	100,757	5298	5.0
Annual Average	76 13	104,792	99,434	5358	5.1

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0803003 (4-12) JEFFERSON COUNTY

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	142,613	133,972	8641	6.1
February	76 02	143,539	135,670	9869	5.5
March	76 03	147,028	138,447	8581	5.8
April	76 04	148,552	141,299	7253	4.9
May	76 05	151,246	144,601	6645	4.4
June	76 06	153,618	145,684	7934	5.2
July	76 07	152,134	144,480	7654	5.0
August	76 08	151,322	143,971	7351	4.9
September	76 09	151,574	144,454	7120	4.7
October	76 10	151,850	145,119	6731	4.4
November	76 11	152,554	144,466	8088	5.3
December	76 12	151,129	144,079	7050	4.7
Annual Average	76 13	149,763	142,187	7576	5.1

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0802005 (4-12) COLORADO SPRINGS CONSORTIUM

Benchmark Years: Currently on files: CPS 1976 EMP. NONE

Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	101,467	93,666	7801	7.7
February	76 02	101,389	93,970	7419	7.3
March	76 03	103,379	95,375	8004	7.7
April	76 04	105,178	98,008	7170	6.8
May	76 05	107,686	101,092	6594	6.1
June	76 06	111,792	104,321	7471	6.7
July	76 07	112,972	104,740	8232	7.3
August	76 08	111,949	105,056	6893	6.2
September	76 09	110,659	104,180	6479	5.9
October	76 10	109,683	103,462	6221	5.7
November	76 11	109,786	102,843	6943	6.3
December	76 12	108,985	102,391	6594	6.1
Annual Average	76 13	107,910	100,758	7152	6.6

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0803508 BALANCE OF COLORADO (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE

Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	215,284	201,220	14,064	6.5
February	76 02	217,580	203,489	14,091	6.5
March	76 03	223,139	207,357	15,782	7.1
April	76 04	222,629	210,055	12,574	5.6
May	76 05	231,973	220,218	11,755	5.1
June	76 06	244,251	230,152	14,099	5.8
July	76 07	245,435	230,908	14,527	5.9
August	76 08	238,863	226,869	11,994	5.0
September	76 09	236,560	225,390	11,170	4.7
October	76 10	237,008	225,500	11,508	4.9
November	76 11	227,475	215,442	12,033	5.3
December	76 12	221,139	208,512	12,627	5.7
Annual Average	76 13	230,112	217,093	13,019	5.7

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0802500 (4-12) DENVER CITY/COUNTY

Benchmark Years: Currently on files: CPS 1976 EMP. NONE

Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	248,572	228,572	20,000	8.0
February	76 02	249,198	231,470	17,728	7.1
March	76 03	255,482	236,210	19,272	7.5
April	76 04	257,732	241,072	16,660	6.5
May	76 05	261,929	246,707	15,222	5.8
June	76 06	267,418	248,553	18,865	7.1
July	76 07	265,479	246,501	18,978	7.1
August	76 08	262,748	245,630	17,118	6.5
September	76 09	264,955	246,456	18,499	7.0
October	76 10	264,174	247,590	16,584	6.3
November	76 11	265,067	246,475	18,592	7.0
December	76 12	263,098	245,816	17,282	6.6
Annual Average	76 13	260,488	242,587	17,901	6.9

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: PS0801502 BOULDER COUNTY (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	70,910	73,821	5089	6.4
February	76 02	79,784	74,757	5027	6.3
March	76 03	81,937	76,287	5650	6.9
April	76 04	82,614	77,858	4756	5.8
May	76 05	83,934	79,678	4256	5.1
June	76 06	85,325	80,275	5050	5.9
July	76 07	84,884	79,611	5273	6.2
August	76 08	84,120	79,331	4789	5.7
September	76 09	84,197	79,597	4600	5.5
October	76 10	84,041	79,964	4077	4.9
November	76 11	84,331	79,603	4728	5.6
December	76 12	83,868	79,390	4478	5.3
Annual Average	76 13	83,162	78,348	4814	5.8

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: SM2670001 FORT COLLINS (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	55,199	52,303	2896	5.2
February	76 02	56,672	53,877	2795	4.9
March	76 03	58,127	55,120	3007	5.2
April	76 04	60,073	57,655	2418	4.0
May	76 05	62,262	59,745	2517	4.0
June	76 06	64,556	61,897	2659	4.1
July	76 07	64,176	61,292	2884	4.5
August	76 08	64,033	61,676	2357	3.7
September	76 09	62,718	60,398	2320	3.7
October	76 10	62,985	60,818	2167	3.4
November	76 11	61,746	58,465	2281	3.7
December	76 12	60,558	58,198	2361	3.9
Annual Average	76 13	61,092	58,537	2555	4.2

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: SM5650000 PUEBLO (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

	Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	48,392	45,378	3014	6.2
February	76 02	49,496	45,907	3589	7.3
March	76 03	50,408	46,916	3492	6.9
April	76 04	51,239	48,339	2900	5.7
May	76 05	51,823	49,084	2739	5.3
June	76 06	53,583	50,131	3452	6.4
July	76 07	53,621	50,060	3561	6.6
August	76 08	52,401	49,302	3099	5.9
September	76 09	52,372	49,204	3168	6.1
October	76 10	53,011	49,513	3498	6.6
November	76 11	52,404	47,564	4840	9.2
December	76 12	52,229	47,946	4283	8.2
Annual Average	76 13	51,748	48,278	3470	6.7

OMB. 44R1621

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
Historical Report on Labor Force and Employment

Region: 07 State: 08 COLORADO (1-2) Date Submitted: 2/16/77

Area: SM3060004 GREELEY (4-12)

Benchmark Years: Currently on files: CPS 1976 EMP. NONE
Enter if new or changed: CPS 19 (14-15) EMP. 1975 (18-19)

Year/Month (20-24)	Civilian Labor Force (26-34)	Employment (36-44)	Unemployment Number (46-54)	Unemployment Rate (56-64)
January	76 01	52,299	49,837	2462	4.7
February	76 02	53,191	50,955	2236	4.2
March	76 03	54,529	52,012	2517	4.6
April	76 04	56,233	54,294	1939	3.4
May	76 05	58,352	56,437	1915	3.3
June	76 06	61,220	58,822	2398	3.9
July	76 07	61,562	59,051	2511	4.1
August	76 08	61,041	59,026	2015	3.3
September	76 09	59,942	57,986	1956	3.3
October	76 10	60,150	58,031	2119	3.5
November	76 11	57,529	55,271	2258	3.9
December	76 12	55,882	53,570	2312	4.1
Annual Average	76 13	57,661	55,441	2220	3.9

State Employment and Training Service Council (SETSC)

In accordance with the standards set forth in the Comprehensive Employment and Training Act of 1973, the State Employment and Training Services Council was established. The Council serves as an advisory body to the Governor on CETA and other training and employment related activities within the state.

The specific functions of the Council are:

Reviewing prime sponsor plans, proposed modifications, and comments thereon.

Review State agency plans for providing services to prime sponsors.

Making recommendations to prime sponsors, agencies providing manpower services, the Governor, and the general public on improving the coordination and effectiveness of manpower services within the State.

Monitoring continuosly (A) the operation of programs conducted by prime sponsors in the State and (B) the availability, responsiveness, adequacy, and effective coordination of State services provided by all manpower-related agencies. The monitoring conducted by State Manpower Services Council shall include an emphasis on reviewing statewide and inter-prime sponsor issues of utilization and coordination of plans and operations in contiguous areas. The prime sponsors and State agencies must be defined by the State Manpower Services Council and publicized to all prime sponsors and State agencies affected prior to their being implemented; and

Submitting an annual report to the Governor which will be a public document and issuing such other studies, reports or documents to the Governor and prime sponsors as the State Manpower Services Council believes necessary to effectively carry out the Act.

COMMITTEES

Four standing committees have been established by the Council whose responsibilities are to perform the following functions.

STEERING COMMITTEE:

The Committee gives direction to the SETSC and is empowered to act for SETSC between meetings.

COMMUNITY NEEDS

With the assistance of the SETSC staff developed a process for the organization and review of manpower related data. This process includes methodology which permits its use in any prime sponsor area.

Initial recommendations are made to the SETSC body, as a whole, regarding priorities among prospective client groups and potentially targetable jobs.

In company with the other two sub-committees and the Steering Committee a state wide plan for targeting and delivering manpower services, which while reflecting to an extent the views of the prime sponsors, also provides leadership from a state wide perspective.

SERVICES COORDINATION:

This Committee concerns itself with issues that involve two or more agencies. Problems are identified, analyzed, and alternative solutions are presented to SETSC as a whole. An active inventory of manpower programs operating within the State of Colorado is maintained and organized on a county by county basis.

MONITORING COMMITTEE:

The Committee reviews performance of prime sponsors in carrying out the objectives of SETSC in meeting the community needs as outlined by the SETSC Council.

The Committee determines the extent to which manpower services are being provided throughout the State, and reviews the coordination of manpower related, as well as non-manpower related activities to determine the success of these efforts.

Provides for and participates with the SETSC staff in the preparation of the Annual Report to the Governor.

MEMBERSHIP

Members of the Council are appointed by the Governor and include representatives of prime sponsors, the State Board for Vocational Education, the State Employment Service, and any State agency the Governor believes has an interest in manpower or manpower-related services within the State. Representatives are also appointed from organized labor, business and industry, the general public, community based organizations, and from the population to be served under the Act.

ACTIVITIES

The Council was expanded this year to 31 members to provide more equitable representation of labor, industry, and the public-at-large. Committees were structured to enhance the Council's effectiveness as an advisory body to the Governor and as a resource of information for prime sponsors and other manpower deliverers. Special efforts were made by the Council to effectuate specific linkage efforts with prime sponsors and avoid duplication of services.

FY'77 RECOMMENDATIONS TO THE GOVERNOR

It is recommended that the following priorities be established for FY '77.

1. That the Council be charged with the development of job creation and special target group efforts utilizing 4% discretionary dollars.
2. That the Council become the focal point of information on federal and state manpower programs, as well as proposed and new legislation affecting manpower deliverers; and that this information be disseminated appropriately.
3. That the Council enhance the State's economic and labor market information to be provided prime sponsors, particularly for the creation of relevant manpower programs.

STATE EMPLOYMENT & TRAINING SERVICES COUNCIL MEMBERSHIP — FY 77 — Revised 3/9/77

Representative	Category	Alternate	Committee
Prime Sponsor & State Agencies			
Mr. Harold Anderson Chairman Jefferson Cty. Bd. of Cty. Comms 17000 Arapahoe St. P.O. Box 232 Golden, CO 80219	Jefferson Cty.	Mr. Edward Grantz, Director Jefferson County Manpower 8790 W. Colfax, No. 200 Lakewood, CO 80215 232-8020	Services Coord.
Ms. June Steinmark, Chairperson Weld Cty. Bd. of Cty. Comms. P.O. Box 1805 Greeley, CO 80631	Weld Cty.	Mr. Walter Speckman, Dir. Weld Cty. Manpower Human Resources Department P.O. Box 1805 Greeley, CO 80631 351-6100	Services Coord.
Mr. Al Hayden, Chairman Pueblo Cty. Bd. of Cty. Comms. Pueblo County Courthouse Pueblo, CO 81003	Pueblo Cty.	Mr. John Romero, Dir. Pueblo Manpower Admin. 720 N. Main St., Suite 320 Pueblo, CO 81003 545-7837	Monitoring
The Honorable Richard D. Lamm Governor of Colorado State Capitol Building Denver, Colorado 80203 893-2471	Bal. of State	Mr. Burton L. Carlson, Dir. Div. of Emp. & Training 251 E. 12th Ave. Denver, CO 80203 893-2400, Ext. 277	Serv. Coord., Chairman & Steering Comm.
Mr. William Lopez, Chairman Larimer Cty. Bd. of Cty. Comms P.O. Box 1190 Ft. Collins, CO 80521 221-2100	Larimer Cty.	Mr. John Priest Larimer Cty. Manpower P.O. Box 1190 Ft. Collins, CO 80521 221-2100, Ext. 476	Community Needs
The Hon. William McNichols, Jr. Mayor of Denver City & County Building Denver, CO 80202	Denver Cty.	Mr. Robert Joyce Denver Manpower Admin 1037 - 20th Street Denver, CO 80202 892-7131	Steering Comm. Chairman
Mr. Pete Mirelez, Chairman Adams Cty. Bd. of Cty. Comms. Courthouse 4th & Bridge Streets Brighton, CO 80601 659-2120	Adams County	Mr. Doug. Cramer, Director Adams County Manpower 7100 Broadway Unit 3-L Denver, 80221 426-1550	Services Coord.
The Hon. Larry Ochs Mayor of Colo. Springs P.O. Box 1575 Colo. Springs, CO 80901 573-8061	Colo. Springs/ El Paso Cty.	Mr. Ray Rodriquez CETA Administrator Colo. Springs/El Paso Cty. CETA Consortium 105 E. Vermijo, Suite 320 Colo. Springs, CO 80901 471-6870	Monitoring

STATE EMPLOYMENT & TRAINING SERVICES COUNCIL MEMBERSHIP — FY 77 — Revised 3/9/77

Representative	Category	Alternate	Committee
Prime Sponsor & State Agencies			
Mr. Tom Eggard Arapahoe Cty. Bd. of Cty. Comms Arapahoe Cty. Courthouse 5606 South Court Place Littleton, CO 80121	Arapahoe Cty.	Ms. Vicki O'Quinn Program Director Arapahoe County Manpower 3331 South Broadway Englewood, CO 80110 761-9501	Comm. Needs
Mr. Wally Toevs, Chairman Boulder Cty. Bd. of Cty. Comms Courthouse Boulder, CO 80302 443-2755	Boulder Cty.	Mr. Richard Rautio, Director Boulder County Manpower 2750 Spruce Boulder, CO 80302 441-3985	Comm. Needs
Mr. Lee White Governor's Office State Capitol Denver, CO 80203 892-2325	Human Serv. Planning Council	Ms. Penelope Nelson	Serv. Coord.
*Mr. John I. Lay, Exec. Dir. Dept. of Labor & Employment 251 E. 12th Ave. Denver, CO 80203 893-2400, Ext. 220 or 223	Dept. of Labor & Employment	Mr. Armando Quiroz Dept. of Labor & Employment 251 E. 12th Ave. Denver, CO 80203 893-2400, Ext. 352	Steering Comm.
Dr. William D. Woolf, Dir. Occupational Education St. Bd. for Comm. Colleges & Occ. Education 1525 Sherman Street Denver, CO 80203 892-3071	Vocational Education	Mr. Robert L. Perry Occupational Education St. Bd. for Comm. Colleges & Occ. Education 1525 Sherman Street Denver, CO 80203 892-3071	Comm. Needs Steering
Business & Labor			
Mr. Frank Gallegos AFL/CIO State Rep.—HRD Institute 90 Madison Street, Suite 405 Denver, CO 80206 321-2977	AFL/CIO	Ms. Kathy Karrick AFL/CIO 90 Madison Street, Suite 405 Denver, CO 80206 321-2977	Steering
Ms. Zelda Bransted Secretary/Treasurer Colo. Labor Council AFL/CIO 360 Acoma St., Room 300 Denver, CO 80223 733-2401	Labor	Mr. Norman N. Pledger, Pres. Colo. Labor Council, AFL/CIO 360 Acoma St., Room 300 Denver, CO 80223 733-2401	Comm. Needs

*Non-voting membership except in the case of ties

Mr. Jim Irwin, President Management Services Co. P.O. Box 47 Montrose, CO 81401 249-8416 or 249-3479 Home: 249-8512	Western Area III		Monitoring Chairman & Steering

Representative	Category	Alternate	Committee
Business & Labor			
Mr. Charles Johnson Honeywell Corporation 4800 E. Dry Creek Road Englewood, CO 80217 771-4700	Colo. Assn. of Comm. & Industry	Nolan A. Stone, Jr. Honeywell Corporation 4800 E. Dry Creek Road Englewood, CO 80217	Monitoring
Ms. Nancy Brigden Mt. Bell Marketing 1011 - 9th Avenue Greeley, CO 80631 1-356-8000	Business	Dr. Kathleen Blumhagen Colo. Comm. on the Status of Women 1525 Sherman Street, No. 600C Denver, CO 80203 892-2821	Comm. Needs
Mr. Paul Emrick 360 Acoma Street, Room 210 Denver, CO 80223 722-2333	Bldg.-Trades Council	Mr. Lee Overholt Journeyment Plumbers & Gas Fitters Local Union No. 3 Denver, CO 80223 722-2333	Monitoring
General Public & Population to be Served			
Mr. Jim Miles Lower Ark. Valley Council of Governments Bent County Courthouse Las Animas, CO 81054 456-0692	LAV-COG		Serv. Coord.
Ms. Ruth Correll 320 - 20th Street Boulder, CO 80302 443-1893	Public-at- Large	Ms. Mary Sylvester 4331 East 23rd Avenue Denver, CO 80207 388-7117 (Home) 861-7598 (Office)	Comm. Needs
Mr. Ivan Vasquez 345 Harrison Loveland, CO 80537 667-7938 (Home) 353-6433 (Office)	American G.I. Forum	Mr. Angelo Valesquez 1060 Bannock Operation SER Denver, CO 80204	Serv. Coord.
Ms. Beverly Hiza, State Pres. League of Women Voters 375 Auburn Boulder, CO 80302 494-8010	Leage of Women Voters	Mrs. Marcile Wood 1920 Sheeley Dr. Ft. Collins, CO 80521 482-6590	Steering & Monitoring

Rep. Polly Baca Barragan 8747 Santa Fe Drive Thornton, CO 80221 428-8894			Comm. Needs
Mr. Magdaleno M. Avila, Exec. Dir. Colo. Migrant Council 665 Grant Street Denver, CO 80203 837-1911	Seas. & Migrant Farmworkers	Mr. Ricardo La Fore Deputy Director Colo. Migrant Council 665 Grant Street Denver, CO 80203 837-1911	Comm. Needs
Mr. C. Douglas Robideaux Denver Indian Center Manpower Program 1525 Josephine Street Denver, CO 80206 320-4575	Denver Indians		Comm. Needs

Representative	Category	Alternate	Committee
General Public & Population to be Served			
Mr. Len E. Gilmer United Veterans Comm. of CO. 1695 Quivas Denver, CO 893-2384	Veterans		Monitoring
Mr. Herb Angle N.E. CO. Council of Governments Northeastern Jr. College P.O. Box 1782 Sterling, CO 80751 522-0040			Monitoring
Mr. Russ Binicki, Director La Puente Group Home P.O. Box 632 Alamosa, CO 81101 589-2476			Monitoring
Mr. Arthur Valdez, Director Northern CO. Consortium, Inc. 10465 Melody Drive Melody Building, Suite 210 Northglenn, CO 80233 452-9033		Mr. Paul Sandoval Northern CO. Consortium 10465 Melody Drive Melody Building, Suite 210 Northglenn, CO 80233 452-9033	Serv. Coord.

GOVERNOR'S DISCRETIONARY FUNDS: SECTION 106

STATE EMPLOYMENT AND TRAINING SERVICES COUNCIL (SETSC) (1%)

Section 103(d) of the CETA Act provides that one (1) percent of the funds allocated to the state's prime sponsors under Title I shall be provided for staff and other necessary services in support of Manpower Services Councils in performing its functions under Section 95.13 (d) of the Regulations.

The Governor provided from his discretionary fund, the sum of $140,791 to support activities of the State Employment and Training Services Council in Fiscal Year 1976.

STATE MANPOWER SERVICES (4%)

Four (4) percent of the funds allocated to Colorado prime sponsors under Title I of CETA are made available to the Governor for statewide services and special impact programs. As provided in Section 106 of the CETA Act, funds available may be used to support statewide activities such as:

1. Statewide Manpower Services -

   Provide services throughout the State by State agencies responsible for employment and training and related services.

2. Special Rural Programs -

   Provide financial assistance for special programs and services designed to meet the needs of rural areas outside major labor market areas.

3. Compile Planning Information -

   Develop and publish information regarding economic, industrial, and labor market conditions.

4. Technical Assistance to Prime Sponsors -

   Provide to any prime sponsor serving an area within the state information and technical assistance that is appropriate to assist a prime sponsor in developing and implementing its programs.

5. Experimental and Demonstration Programs -

   Carry-out special model training and employment programs and related services.

The following ten (10) programs were recommended for funding by the State Employment and Training Services Council and approved by the Governor. Total expenditures at the end of the fifth quarter of FY 76 stood at $662,284. Included in this total is the combined FY 76 base and transition quarter allocations of $591,739. Four hundred thirty-two (432) participants were enrolled with 157 entering unsubsidized employment and 78 terminating positively. Continued enrollment at the end of the quarter was 141.

FY 1976
4% CONTRACTS

CONTRACTOR	FUNDING LEVEL
1. Colorado Commission on the Status of Women	$46,030
Program: "Current Impact and Future Potential: CETA and Women in Colorado"	
Purpose: To improve the applicability and effectiveness of CETA Programs in serving the needs of Colorado women.	
2. Colorado Council on Migrant & Seasonal Farmworker and Their Families, Inc.	$82,648
Program: "Data Analysis and Research Program"	
Purpose: In-house computer system to supply necessary information for future funding of all rural programs in Colorado.	
3. City of Colorado Springs, Office of the Mayor, CETA Administration	$26,936
Program: Vocational Evaluation Component for the City of Colorado Springs/El Paso County CETA Delivery System	
Purpose: Establishment of formal Vocational Evaluation Component within its delivery system of services; to coordinate and monitor the delivery of vocational evaluation services to be utilized as a resource by each of the six staffing grant agencies for their clients.	
4. City & County of Denver, Office of the Mayor, Denver Manpower Administration	$110,000
Program: Older Workers' Project	
Purpose: Increase placement of older workers; foster employer receptivity; develop linkage with service agencies; seek long range funding, staff training in older worker employability development.	
5. Denver Opportunity	$14,043
Program: Alcoholic Counseling and Rehabilitation Program	
Purpose: To meet the needs of local alcoholics and their families through direct services, coordinated services and referral services; development of employment opportunities	
6. Pueblo Manpower Administration	$31,000
Program: Ex-Offender Program	
Purpose: To place twenty participants in on-the-job training positions	

FY 75
CONTRACTS

CONTRACTOR	FUNDING LEVEL

7. Western Interstate Commission for Higher Education (WICHE) — $38,980

   Program: Colorado W.I.C.H.E. (Community based Rehabilitation Pilot Program)

   Purpose: A pilot program to provide educational field experience for 20 handicapped interns (students) to demonstrate the abilities and capabilities of the handicapped.

8. Larimer County Commissioner Manpower Department — $61,000

   Program: Larimer County Community Corrections Project

   Purpose: To increase protection of society by lowering the crime rate through decreasing recidivism of offenders; to further test the hypothesis that increased incarceration in and of itself is counter to the maximization of rehabilitation efforts.

9. Employ-Ex, Inc. — $45,000

   Program: Ex-Offender Project

   Purpose: To assit the criminal offender through the often difficult transition from convicted criminal to productive citizen. To create, coordinate and deliver employment opportunities and related resocialization services for felony offenders.

10. American G.I. Forum — $136,102

    Program: Veterans Outreach Program

    Purpose: To identify disadvantaged veterans in the target areas who are in need of assistance with emphasis on Spanish speaking veterans; to mobilize and coordinate community resources; to provide intensive counseling and referral to training or education; to develop job opportunities and a job bank system.

STATE BOARD FOR VOCATIONAL EDUCATION (5%)

The Colorado State Board for Community Colleges and Occupational Education is the administering agency for the five (5) percent portion of the Governor's Special Grant. The State Board provides vocational training and services to ten (10) Colorado Prime Sponsors as described in the Comprehensive Employment and Training Act (CETA) and the Federal Regulations:

> Ceta Act, Sec. 112 (a): "The Secretary shall make grants to Governors to provide financial assistance, through State vocational education boards, to provide needed vocational educational services in areas served by prime sponsors."
>
> Federal Regulations 95.56 (a) (i): "The Governor shall provide vocational education funds received by special grant to the State Vocational Education Board . . . the training and services detailed in a non-financial agreement with the prime sponsor . . . . ."

The State Board has both a regulatory and service function under this law. These service functions, briefly described, are the responsibility of the CETA Section of the State Board.

I. Administrative Function - The State Board has the responsibility to administer and supervise the 5% expenditures in vocational and related training programs for CETA.

II. Services Function - The State Board is to provide needed vocational education services in areas served by prime sponsors. Since each sponsor area is autonomous within itself, the service requested may not be consistent from one area to another. Various services are presented and available based on the negotiation of such services through the process of completing the non-financial agreement.

During FY '76 the State Board administered vocational education (5%) funds amounting to $966,559. Also during this period, seven prime sponsors and two Title III recipients contracted with the State Board to meet additional training needs. This amounted to aprroximately $300,000.

There were approximately 1300 individual referrals trained through existing approved vocational training porgrams in various Community Colleges, Area Vocational Schools and Private Schools throughout the state. In addition, there were approximately 348 students trained in 12 separate class-size programs which were developed to meet the one-time employment needs of CETA participants. Two of the class-size programs stood out as being very successful in fiscal year 1976. Boulder Valley Vocational Technical School conducted a Secretarial program which placed over 92% of the 50 graduates. The Operating Engineers Union conducted a pre-apprenticeship program for heavy equipment operators and all the students that participated received job offers in the occupational skill in which they were trained.

Much of the administration time spent was devoted to four areas: (1) Development and evaluation of class-size programs, (2) Monitoring of individual referral training, (3) Administering and accounting for 5%, Title I and Title III funds, and (4) Effecting the best possible coordination of planning for 10 prime sponsors and their sub-contractors.

The most difficult obstacle encountered during fiscal year 1976 was the establishment of a plan that would meet the needs of each individual prime sponsor yet provide for effective coordination on a statewide basis without duplicating existing services.

For the current fiscal year of 1977 the State Board is directing its attention to a planning process that would include more class-size programs. These programs would be more closely planned with business and industry in order to establish a direct employment need. Consideration will be given to operating some training programs within the industry that is to provide the employment. The State Board is also looking at effecting a closer coordination of all vocational training provided through CETA and the vocational training provided by other agencies involved in manpower training throughout the state. Such improvement in the coordination picture should provide for better quality programs with higher placement and reduce much of the unnecessary duplication involved in the manpower training process.

Our ultimate objective for fiscal year 1977 is to develop vocational training programs that will improve the placement potential of the participants for which CETA is mandated to serve.

CETA TITLE I SECTION 112

SUPPLEMENTAL VOCATIONAL EDUCATION

DISTRIBUTION TO COLORADO PRIME SPONSORS, FY 1976

Prime Sponsor Area	Admin. Costs		Voc. Ed. Funds		Total Allocation		
	FY-76	Trns Q	FY-76	Trns Q	FY-76	Trns Q	TOTAL
Adams County	7,196	1,799	32,079	8,020	39,275	9,819	49,094
Arapahoe County	4,631	1,157	20,642	5,161	25,273	6,318	31,591
Boulder County	6,641	1,660	29,606	7,402	36,247	9,062	45,309
El Paso/Colorado Springs	11,059	2,765	49,298	12,324	60,357	15,089	75,446
Denver County	41,580	10,395	185,351	46,338	226,931	56,733	283,664
Jefferson County	6,806	1,702	30,342	7,585	47,148	9,287	46,435
Larimer County	4,509	1,127	20,098	5,025	24,607	6,152	30,759
Pueblo County	7,855	1,963	35,015	8,754	42,870	10,717	53,587
Weld County	4,636	1,159	20,667	5,167	25,303	6,326	31,629
Balance of State	31,439	7,861	140,150	35,036	171,589	42,897	214,486
Sub-Total FY76	$126,352		$563,248		$689,600		
Sub-Total Trans. Quarter		$31,588		$140,812		$172,400	
TOTALS	$157,940		$704,060				$862,000
Grant Administration					$ 14,354	$ 3,588	17,942
TOTAL Vocational Education (5%) Funding Allocation							$879,942

SUMMARY OF VOCATIONAL EDUCATION (5%) ACTIVITY
BY PRIME SPONSOR AREA
FISCAL YEAR 1976

	EXPENDITURES			ENROLLMENTS		
	PLAN	ACTUAL	PERCENT PLAN	PLAN	ACTUAL	PERCENT PLAN
Adams County	$ 54,663	$ 58,863	108	124	107	86
Arapahoe County	41,307	39,598	96	106	306	289
Boulder County	39,401	37,494	95	64	65	102
El Paso/Colorado Springs	85,973	77,041	90	148	146	99
Denver County	363,979	349,687	96	338	371	110
Jefferson County	58,373	59,852	103	120	109	91
Larimer County	25,734	28,915	112	67	56	84
Pueblo County	65,267	51,185	78	118	92	78
Weld County	26,462	13,477	51	81	63	129
Balance of State	322,691	250,447	78	395	342	87
TOTAL	$1,083,850	$966,559	89	1561	1657	106

LOCAL PRIME SPONSORS

The following contains a synopsis of the area served and the organizational structure of each Colorado Prime Sponsor.

ADAMS COUNTY

Area Served

Adams County is located in the northeast section of the Denver Metropolitan area. The population of the prime sponsor area according to the 1970 Census was 185,789 including 1,355 Blacks and 26,277 Spanish Surnamed. The principle industry is wholesale and retail trade, but being bordered by Denver on the Southwest, it participates in Denver's economy.

Organizational Structure

Adams County's chief elected body and CETA prime sponsor is the Board of County Commissioners. The Commission established a Manpower Division with in county government to provide management and administration of CETA to Adams County residents. In 1974 the Board of County Commissioners established the Adams County Manpower Planning Council to act as an Advisory Council to the Prime Sponsor. The functions of the Planning Council are to:

1) Submit recommendations regarding program goals/plans, policies and procedures.

2) Monitor and provide for objective evaluations of employment and training programs conducted in Adams County, and

3) Provide continuing analysis of needs for employment, training and related services in areas which will aid the Board in providing comprehensive service.

CHIEF ELECTED OFFICIAL

Mr. Pete Mirelez, Chairman
Board of County Commissioners
Courthouse
4th & Bridge Streets
Brighton, Colorado 80601

DIRECTOR

Mr. Doug Cramer
Adams County Manpower
7100 Broadway, Unit 3-L
Denver, Colorado 80221
PH: 426-1550

ARAPAHOE COUNTY

Area Served

Arapahoe County is a suburban county located South and Southeast of Denver. Within the Western Area of the county is contained an expanding edge of the Denver Metropolitan Area.
According to the 1970 Census the population of Arapahoe County was 162,142 and the labor force was 69,133. Although Arapahoe County has its own industries the principle being wholesale and retail trade, the county's residents provide a large share of Denver's work force.

Organization Structure

The chief elected body and CETA prime sponsor for Arapahoe County is the Board of County Commissioners. Overall management of CETA is coordinated through the County's Personnel/Budget Office. Program Service delivery is accomplished through the Arapahoe County Employment and Training Resource Center. The major contractors for services are the Community and Vocational Colleges within Arapahoe County for provision of individual client training needs.
The Advisory Board Council, provides recommendations for program plans, goals, policies and procedures. The Council also helps to assure maximum utilization of community resources.

CHIEF ELECTED OFFICIAL

Tom Eggard, Chairman
Board of County Commissioners
5606 So. Court Place
Littleton, Colorado 80121

DIRECTOR

Ms. Vicki O'Quinn
Arapahoe County Manpower
3311 So. Broadway
Englewood, Colorado 80121
PH: 761-9501

BOULDER COUNTY

Area Served

The prime sponsor area of Boulder County is an area of 750 square miles, with a 1970 Census population of 131,889. Current estimates perceive a population of 171,500. Its largest sub-areas are the City of Boulder located 30 miles northwest of Denver and the City of Longmont, located in the northeast corner of the County. Labor demand in the public sector is dominated by research institutions consisting of federal government research laboratories and university research centers.

Organizational Structure

The Boulder County Commissioners are the CETA Prime Sponsor and the chief elected body of Boulder County. The Division of Employment and Training within the County's Department of Human Resources administers most activities of the Boulder County CETA program. During FY 76 the Department of Human Resources sub-contracted with SER/Jobs for Progress to provide on-the-job training, and the Community Action Program to provide for the operation of the youth employment program.
The Advisory Council to the County Commissioners submits recommendations for program plans, goals, policies and procedures. In addition, the Council provides recommendations as to selection and designation of employing agents under CETA.

CHIEF ELECTED OFFICIAL

Mr. Wally Toevs, Chairman
Board of County Commissioners
Courthouse
Boulder, Colorado 80302

DIRECTOR

Mr. Richard Rautio
Boulder County Manpower
2750 Spruce St.
Boulder, Colorado 80302
PH: 441-3985

COLORADO SPRINGS/EL PASO COUNTY CONSORTIUM

Area Served

El Paso County, which includes the City of Colorado Springs, is located approximately 60 miles South of Denver. Foothills and mountains characterize the Western portion of the County while Eastern El Paso County is characterized by open plains. Government, Services, and Wholesale and Retail Trade are the principal industries of the County. The 1970 Census indicated a total County population of 235,972 which included a population of 135,060 for Colorado Springs. As of 1970, the County population was composed of 5.2% Blacks and 8.5% Spanish Surnamed.

Organizational Structure

The Colorado Springs/El Paso County Consortium acts as Prime Sponsor for the total of El Paso County, within which is the jurisdiction of the City of Colorado Springs and the balance of El Paso County. The Consortium Agreement provides for joint City & County CETA program operations and a decision-making structure composed of the Colorado Springs City Council and the El Paso County Board of Commissioners. A Consortium Policy Committee consisting of the Mayor of the City of Colorado Springs and the Chairman of the Board of County Commissioners provides overall direction and policy for the delivery of CETA within El Paso County. Under the Agreement the City of Colorado Springs is designated to administer and operate CETA programs through the City's Department of Community Development.
A resolution adopted by the City of Colorado Springs/El Paso County provides for a Manpower Planning Council. The Council consists of nine members, representing the interests of El Paso County, whose function is to advise the Consortium and Consortium Policy Committee in developing and evaluating the programs and services provided under CETA in El Paso County.

CHIEF ELECTED OFFICIAL

The Honorable Lawrence Ochs
Mayor of Colorado Springs
P.O. Box 1575
Colorado Springs, Colorado 80901

DIRECTOR

Mr. Ray Rodriquez
Colorado Springs/El Paso
County Consortium
105 E. Vermijo, Suite 320
Colorado Springs, CO 80901
PH: 471-6870

DENVER

Area Served

The City & County of Denver is a single jurisdiction which retains the aspects of both a City and a County Government. Denver is the commercial & training center for the surrounding areas. It covers an area in excess of 95 square miles, and is the core city for a seven county SMSA whose populations exceeds one million. The City and County itself is located in the northeast central part of the State and had a 1970 Census population of 514,678 including 47,011 Black Americans and 86,345 Chicanos.

Organizational Structure

Denver's chief elected official and CETA prime sponsor is the Mayor. The Manpower Administration under the Mayor provides management and delivery of services for CETA in Denver. During FY 76 Denver's Title I CETA operated through four sub-contracted service centers: (Freedom House Job Placement Center, Opportunities Industrialization Center, SER/Jobs for Progress, and the Singer Career Development Center) and the Denver Manpower Center.
During the Summer of 1974, the Mayor created the Manpower Advisory Council (MAC) and charged it with assisting him in long-range planning, performance goals, and broad-range analysis in the manpower area. The MAC consists of 19 members representing a wide-range of interests and backgrounds.

CHIEF ELECTED OFFICIAL

The Honorable William McNichols, Jr. Mayor
City & County Building
1437 Bannock St.
Denver, Colorado 80202

DIRECTOR

Mr. Robert J. Joyce
Denver Manpower Administration
1037 20th St.
Denver, Colorado 80202
PH: 892-7131

JEFFERSON COUNTY

Area Served

Jefferson County consists of both mountain and plain terrain and covers 780 square miles. While the majority of the land area is mountainous, the bulk of the county's 233,114 residents live on the low lying areas. Jefferson County is located in the central part of the State and provides the Western boundary for Denver. The economic conditions of the county reflect its inclusion in the Denver Metropolitan area. Although wholesale and retail trade is the principle industry of the county one of the largest employers is the Federal Government.

Organizational Structure

The Jefferson County Board of Commissioners is the chief elected body of the county and acts as prime sponsor for Jefferson County. The Jefferson County Manpower Administration (JCMA) was established within the county government to manage and administer CETA programs to county residents. All needed training and support services are provided on an individual basis for each participant by the Manpower Administration. The Jefferson County Manpower Advisory Council, established by the Board of Commissioners, advises the JCMA in setting of basic goals, policies and procedures for its program under the CETA Act. The Advisory Council also makes recommendations regarding program plans, and provides for continuing analysis of needs for employment, training and related services in the Jefferson County area.

CHIEF ELECTED OFFICIAL

Mr. Hal Anderson, Chairman
Board of County Commissioners
1700 Arapahoe
P.O. Box 232
Golden, Colorado 80419

DIRECTOR

Mr. Edward Grantz
Jefferson County Manpower
8790 West Colfax, Suite 200
Lakewood, Colorado
PH: 232-8020

LARIMER COUNTY

Area Served

Larimer County is located in North central Colorado and has the Medicine Bow mountain range as its Western boundary and Wyoming as its Northern boundary. The county covers an area of 2,640 square miles and is composed of mountains to the West and plains in the East. The preliminary 1975 Census indicated that Larimer County had a population of 120,900. Approximately 71% of the population is urban and 29% is rural. Employment in Larimer County is primarily concentrated in wholesale and retail trade and government.

Organizational Structure

Larimer County's CETA prime sponsor and chief elected body is the three member Board of County Commissioners. The Board established the Larimer County Manpower Department to administer CETA programs within the County. Delivery of services is provided through the Manpower Department and through a sub-contract with the Colorado Division of Employment and Training (CDET). The CDET's Loveland and Fort Collins Offices provide intake and direct placement services for CETA eligible Larimer County residents. The County Commissioners established the Larimer County Manpower Planning Council to act in an advisory capacity to Commissioners and the Manpower Department. The functions of the Council are to determine needs of Larimer County residents, review CETA program operations and success and identify possible community linkages.

CHIEF ELECTED OFFICIAL

Mr. William Lopez, Chairman
Board of County Commissioners
Courthouse
P.O. Box 1190
Fort Collins, Colorado 80521

DIRECTOR

Mr. John Priest
Larimer County Manpower
P.O. Box 1190
Ft. Collins, CO 80521
PH: 221-2100

PUEBLO COUNTY

Area Served

Pueblo County is located in the Southeast section of the State. The population of Pueblo County as of the 1970 Census was 118,238 and included 1.8% Blacks and 31.4% Spanish Surnamed. The largest employers in Pueblo County by rank are (CF&I) Colorado Fuel and Iron Co., the Pueblo Army Depot and The Colorado State Hospital.

Organizational Structure

Pueblo County is governed by a three member Board of County Commissioners with an appointed County Administrator. The Prime Sponsor for CETA and the Chief Elected body of Pueblo County is the Board of County Commissioners. The Pueblo Manpower Administration (PMS) within the county government, administers the Prime Sponsor's CETA program. The PMA is the main delivery agent of CETA services but has subcontracted with the University of Southern Colorado and Midwest Business College to provide instruction and instructional facilities.

The Manpower Planning Council, as approved by the Board of County Commissioners, acts in an advisory and recommendatory capacity in the areas of planning, policy-making and program implementation of manpower services. In addition, the Planning Council is extensively involved in evaluating and monitoring programs and providing continued analysis of the needs for employment training and related services. All the functions of the Council are augmented by the Prime Sponsor staff.

CHIEF ELECTED OFFICIAL

Mr. Al Hayden, Chairman
Board of County Commissioners
Courthouse
Pueblo, Colorado 81003

DIRECTOR

Mr. John Romero
Pueblo Manpower Administration
720 North Main, Suite 320
PH: 545-7837

WELD COUNTY

Area Served

Weld County is located in the Northern sector of the State. It is one of the largest counties in Colorado and covers 4,004 square miles. Weld County is within fifty miles of the economic center of Colorado, Metro Denver, and is partially dependent on this arrangement for its economic base and labor market. Within Weld County the primary industries are government, agriculture and wholesale and retail trade. According to 1975 preliminary Census data the County had a population of 107,700.

Organizational Structure

The Weld County Board of County Commissioners is the designated Prime Sponsor for the Weld County CETA program. The Board of County Commissioners has assigned program responsibility to the umbrella agency, the Weld County Division of Human Resources. All CETA planning, administration and service delivery is coordinated through the Division of Human Resources to minimize duplication and coordinate existing services within Weld County. The Human Resources Committee functions in a recommending and advisory role in the areas of planning, policy making and program implementation of manpower services to the Weld County Board of Commissioners. In formulating recommendations the Committee is involved in evaluating and monitoring the program to determine if established goals have been met. All the functions of the Human Resources Committee are augmented by staff support.

CHIEF ELECTED OFFICIAL

Ms. June Steinmark, Chairperson
Board of County Commissioners
Post Office Box 1805
Greeley, Colorado 80631

DIRECTOR

Mr. Walter Speckman
Human Resources Department
P.O. Box 1805
Greeley, Colorado 80631
PH: 351-6100

BALANCE OF STATE

Area Served

The Balance of State (BOS) encompasses all areas not served by other Prime Sponsors. The BOS contains 54 counties (see attachment # 1) and an estimated population of 498,835, approximately 20% of the State population. BOS is primarily a rural area covering 89,314 of the State's 104,247 square miles. The BOS economy relies primarily on agriculture activity.

Organizational Structure

The Prime Sponsor for the CETA program in the Balance of State is the Governor of Colorado. The responsibility for program management and administration is lodged with the Division of Employment and Training (CDET) within the Colorado Department of Labor and Employment. The Colorado Division of Employment and Training contracted with three other organizations to provide various employment & training services. These organizations are Colorado Jobs for Porgress/SER, Virginia Neal Blue and the Colorado Migrant Council. SER & Virginia Neal Blue programs are co-located at CDET Job Service Centers throughout the Balance of State area. Five contracts were held during FY 76 to provide Work Experience to CETA eligible participants. Those contractors were the Southeastern Colorado Manpower Services, Inc., San Luis Valley Council of Governments, Upper Arkansas Area Council of Governments, Southern Ute Community Action Program, Inc., Northern Colorado Consortium, and the Huerfano/Las Animas Council of Governments. The BOS Manpower Plannning Council, appointed by the Governor, submits recommendations regarding program plans, and goals to the Department of Labor & Employment. In addition, the Planning Council provides monitoring and evaluation of the CETA program, and an analysis of the needs of the BOS area to be used to determine the CETA program in the BOS. Staff support is provided to the Planning Council by personnel of the Department of Labor & Employment.

CHIEF ELECTED OFFICIAL

Honorable Richard D. Lamm
Governor
State Capitol Building
Denver, Colorado 80203

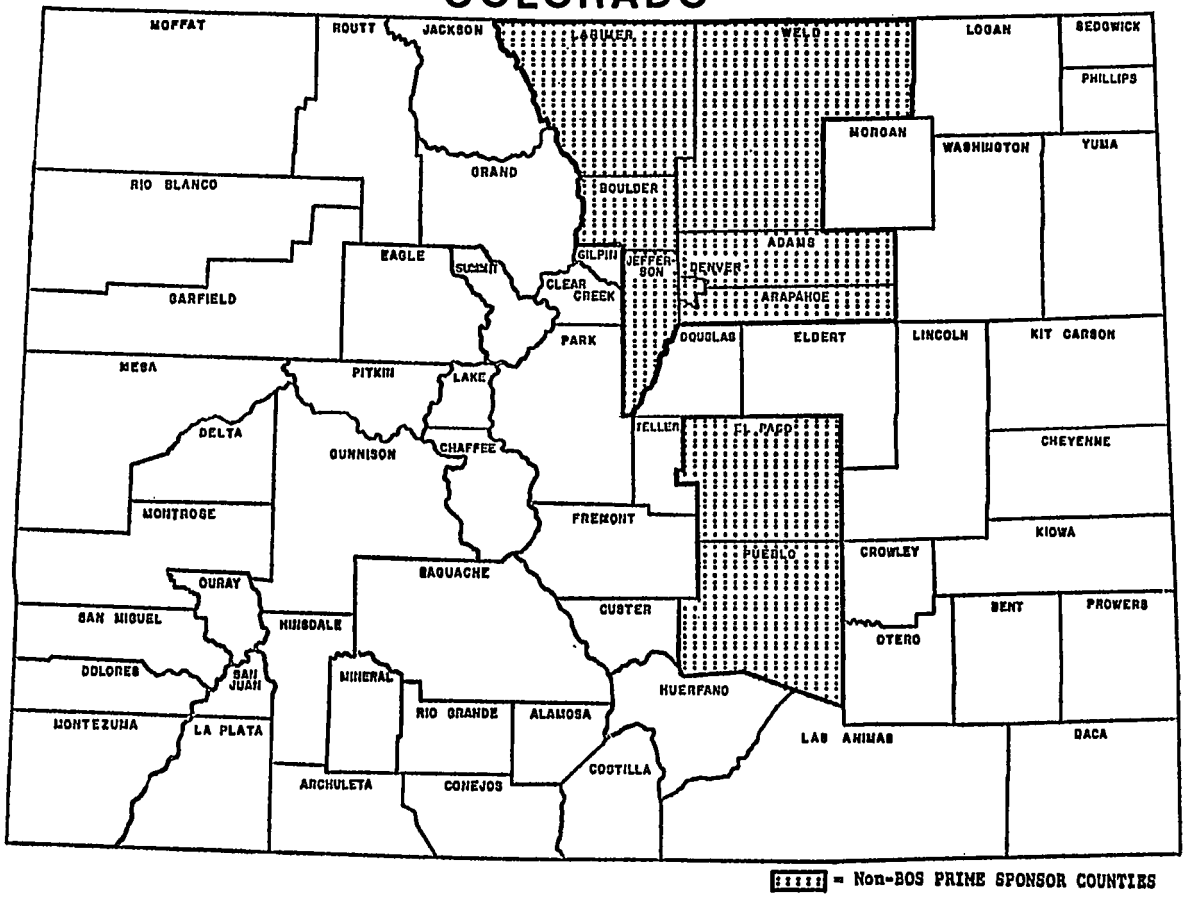
DIRECTOR

Mr. Burton L. Carlson
Division of Employment and Training
251 E. 12th Avenue
Denver, Colorado 80203
PH: 893-2400

BALANCE OF STATE COUNTIES

Alamosa
Archuleta
Baca
Bent
Chaffee
Cheyenne
Clear Creek
Conejos
Costilla
Crowley
Custer
Delta
Dolores
Douglas
Eagle
Elbert
Fremont
Garfield
Gilpin
Grand
Gunnison
Hinsdale
Huerfano
Jackson
Kit Carson
Kiowa
La Plata
Lake
Las Animas
Lincoln
Logan
Mesa
Mineral
Moffat
Montezuma
Montrose
Morgan
Otero
Ouray
Park
Phillips
Pitkin
Prowers
Rio Blanco
Rio Grande
Routt
Saguache
San Juan
Sna Miguel
Sedgwick
Summit
Teller
Washington
Yuma

COLORADO


MOFFAT
ROUTT
JACKSON
LARIMER
WELD
LOGAN
SEDGWICK
PHILLIPS
MORGAN
WASHINGTON
YUMA
RIO BLANCO
GRAND
BOULDER
EAGLE
SUMMIT
GILPIN
JEFFERSON
DENVER
ADAMS
CLEAR CREEK
ARAPAHOE
GARFIELD
PARK
DOUGLAS
ELBERT
LINCOLN
KIT CARSON
MESA
PITKIN
LAKE
TELLER
EL PASO
CHEYENNE
DELTA
GUNNISON
CHAFFEE
MONTROSE
FREMONT
KIOWA
PUEBLO
CROWLEY
OURAY
SAGUACHE
SAN MIGUEL
HINSDALE
CUSTER
BENT
PROWERS
OTERO
DOLORES
SAN JUAN
MINERAL
HUERFANO
MONTEZUMA
LA PLATA
RIO GRANDE
ALAMOSA
LAS ANIMAS
BACA
ARCHULETA
CONEJOS
COSTILLA
::::: = Non-BOS PRIME SPONSOR COUNTIES

FY'76 CETA PROGRAM PERFORMANCE

OVERVIEW

As indicated in the following Table, the State of Colorado received a total Fiscal Year 1976 allocation of $28,885,901 for the operation of its CETA Titles I (Comprehensive Manpower Services), II (Public Service Employment), VI (Emergency Jobs Program), and III (Summer Youth Employment) programs. With this allocation and the use of FY'75 carry-in dollars, 19,023 people received training and subsidized employment under Title I, while 5,295 received subsidized employment under Titles II and VI. The Special Program For Economically Disadvantaged Youth (Title III) provided short-term subsidized employment opportunities for 8,102 of Colorado's disadvantaged youth.

Of the 24,318 participants served in Titles I, II, and VI programs, 9,855 or 40.5% entered unsubsidized employment, while 3,786 or 19.9% of Title I participants reentered school or engaged in other positive action as a result of their participation of CETA.

PRIME SPONSOR CETA ALLOCATIONS
FISCAL YEAR 1976
July 1, 1975 through September 30, 1976

PRIME SPONSOR	TITLE I	TITLE II	TITLE VI	TITLE III	TOTAL
Adams County	$ 910,641	$ 155,370	$ 708,928	$ 323,682	$ 2,098,621
Arapahoe County	548,891	25,452	342,079	88,656	1,005,078
Boulder County	804,421	34,027	561,354	232,647	1,632,449
Denver County	4,501,575	454,828	2,403,271	1,491,081	8,850,755
El Paso/Colo. Springs	1,396,763	291,937	1,130,970	370,687	3,190,357
Jefferson County	910,271	54,205	557,198	129,711	1,651,385
Larimer County	530,089	71,769	310,289	174,336	1,086,483
Pueblo County	786,750	152,562	503,308	271,917	1,714,537
Weld County	574,856	29,212	217,212	210,632	1,031,912
Balance of State	3,403,781	328,165	1,674,386	1,054,348	6,460,680
TOTAL	$14,501,687	$1,597,527	$8,408,995	$4,347,697	$28,885,901

CONCLUSION

The purpose of CETA Title I is to provide manpower training and services which would enhance the development and creation of job opportunities; yet only 53.9 percent of all Title I dollars in Colorado were expended for manpower training activities this fiscal year - a decline of 8.4 percent from the FY'75 level of 62.3 percent.

While the need for subsidized employment is recognized (public service employment), this need could best be addressed with CETA Titles II and VI funds, reserving Title I monies for training. (Public Service Employment activity in Title I increased 7.8 percent over last year's level of 9.5 percent.) In addition to this income maintenance activity, in fiscal years 1975 and 1976 twenty-eight (28%) percent of all Title I dollars in Colorado were expended on Other Activities. Reallocation of some of these dollars can provide more comprehensive training opportunities for the structurally unemployed (youth, handicapped, minorities, women, and older workers) and better equip them to compete for jobs which would not traditionally be available to them.

Colorado is now experienceing a slow recovery from the effects of the recession. While jobs are not yet plentiful, more and more are being recovered in the private sector. Thus, attention of prime sponsors should turn to providing a trained work force to fill these jobs.

TITLE I

With a total fiscal year 1976 allocation of $14,501,687 and the use of FY'75 carry-in dollars employment and training opportunities were provided to 19,023 participants in the Title I program. As of the end of the fiscal year (September 30, 1976) 8,814 participants entered unsubsidized employment, 3545 terminated positively* and 2902 remained currently enrolled in some phase of CETA activity.

As can be seen in the Summary Comparison of Title I activity for fiscal years 1975 and 1976, overall placement activity has improved significantly with an increase of 16% over that of 1975. Indirect placements or placements resulting from CETA training increased by 10%, while direct placement (no CETA training) and self placements decreased by 7.9% and 2.1% respectively.

In the area of total expenditures by program activity significant changes were seen in increased expenditures in on-the-job training and public service employment, 4% and 7.8% respectively, and the decrease in expenditures for work experience activity of 10.9% over that of fiscal year 1975.

A summary of Prime Sponsors' Comprehensive Manpower Plans for FY'76 is outlined in Tables I thru V. Tables VI thru VIII summarized accrued expenditures for the fiscal year, as well s characteristics of persons served.

*positive termination - enrollment in full-time academic or vocational schools, entrance into a branch of the Armed Services, enrollment in activities funded under another CETA title, enrollment in a manpower program not funded under CETA, or completion of program objectives not involving entrance into unsubsidized employment.

TITLE I
SUMMARY COMPARISON OF FY '75 & '76

	FY 75 (1)	% of Total	FY 76 (2)	% of Total
I. Enrolled:	13,794	100%	19,023	100%
1. Classroom Training	1,143	8.3	4,135	21.7
2. OJT	844	6.1	1,719	9.0
3. PSE	541	3.9	1,006	5.3
4. Work Experience	6,716	48.7	1,428	7.5
II. Individuals Terminated:	7,449	100%	16,081	100%
A. Entered Employment	2,890	38.8	8,814	54.8
1. Direct	1,362		3,468	
2. Indirect	981		3,869	
3. Self	547		1,477	
B. Other Positive	2,979	40.0	3,545	22.1
C. Non-Positive	1,580	21.2	3,722	23.1
III. Expenditures:	8,402,000	100%	15,300,920	100%
1. Classroom Training	2,082,000	24.8	3,568,035	23.3
2. OJT	621,000	7.4	1,750,246	11.4
3. PSE	801,000	9.5	2,652,387	17.3
4. Work Experience	2,525,000	30.1	2,928,819	19.2
5. Services to Clients/other	2,373,000	28.2	4,401,433	28.8

(1) Figures reported in Annual Report To The Governor FY '75
(2) Total of Prime Sponsor Activity as exhibited in the Regional Automated System of the U.S. Department of Labor for the quarter ending September 30, 1976.

CETA
TITLE I ALLOCATIONS
FY 1976

	FY 76 BASE ALLOCATION	INCENTIVE	FY 76 TRANS. QUARTER	TRANS QTR. INCENTIVE	TOTAL
Adams County	$ 728,513	$	$ 182,128	$	$ 910,641
Arapahoe County	495,113		123,778		618,891
Balance of State	2,723,025		680,756		3,403,781
Boulder County	643,537		160,884		804,421
Denver County	3,601,260		900,315		4,501,575
El Paso/Colo. Springs	1,015,827	101,583	253,957	25,396	1,396,763
Jefferson County	728,217		182,054		910,271
Larimer County	424,071		106,018		530,089
Pueblo County	680,319		170,080		850,399
Weld County	459,885		114,971		574,856
	$11,499,767	$101,583	$2,874,941	$25,396	$14,501,687

Special Grants to the State	FY76 BASE	TRANS QUARTER	TOTAL
1% (SMSC)	$ 112,633	$ 28,158	$ 140,791
4% (State Services)	563,163	140,790	703,953
5% (Supplemental Vocational Education)	703,954	175,988	879,942
Total	$1,379,750	$344,936	$1,724,686

Title I Summary

Prime Sponsor Total	$14,501,687
Special Grants	1,724,686
Total: CETA Title I	$16,226,373

TITLE I COMPREHENSIVE MANPOWER ACTIVITIES' FY 76
COLORADO PRIME SPONSOR STATEWIDE PROGRAM

SUMMARY

TABLE I

PROGRAM ACTIVITY	EXPENDITURES PLAN	EXPENDITURES ACTUAL	PERCENT OF FUNDS PLAN	PERCENT OF FUNDS ACTUAL	INDIVIDUALS SERVED PLAN	INDIVIDUALS SERVED ACTUAL	PERCENT ACCOMPLISHED
CLASSROOM TRAINING	$4,227,396	$3,568,035	24.0	23.3	3806	4135	108.6
ON-THE-JOB TRAINING	2,161,655	1,750,246	12.3	11.4	1776	1719	96.8
PUBLIC SERVICE EMPLOYMENT	2,715,133	2,652,387	15.5	17.3	911	1006	110.4
WORK EXPERIENCE	3,207,045	2,928,819	18.2	19.1	2554	4123	161.4
SERVICES TO CLIENTS and OTHER ACTIVITIES	5,264,660	4,401,433	30.0	28.8			
TOTAL	$17,575,889	$15,300,920			9047	10983	121.3

SUMMARY BY PRIME SPONSOR AREA OF TITLE I,
COMPREHENSIVE MANPOWER PLANS, FY76

CLASSROOM TRAINING

TABLE II

PROGRAM ACTIVITY	EXPENDITURES PLAN	EXPENDITURES ACTUAL	% OF SPONSORS FUNDS PLAN	% OF SPONSORS FUNDS ACTUAL	INDIVIDUALS SERVED PLAN	INDIVIDUALS SERVED ACTUAL	PERCENT ACCOMPLISHED
Adams County	$ 542,209	$ 407,056	47.4	43.6	863	639	74.0
Arapahoe County	104,879	72,367	17.6	14.1	78	161	206.4
Boulder County	319,040	317,701	32.7	36.0	322	279	86.6
Denver County	1,402,950	1,193,927	25.1	26.6	625	818	130.8
El Paso/Colorado Springs	461,683	422,052	31.0	32.2	438	644	174.0
Jefferson County	324.614	166,742	29.4	18.1	310	317	102.2
Larimer County	122,586	105,241	25.6	26.5	67	89	132.8
Pueblo County	360,190	306,833	31.3	28.6	229	389	169.9
Weld County	82,045	77,473	17.7	18.2	124	125	100.8
Balance of State	507,200	498,643	10.9	11.5	750	674	89.9
TOTAL	$4,227,396	$3,568,035		84.4	3806	4235	108.6

SUMMARY BY PRIME SPONSOR AREA OF TITLE I
COMPREHENSIVE MANPOWER PLANS, FY 76

ON-THE-JOB TRAINING

TABLE III

PROGRAM ACTIVITY	EXPENDITURES PLAN	EXPENDITURES ACTUAL	% OF SPONSORS FUNDS PLAN	% OF SPONSORS FUNDS ACTUAL	INDIVIDUALS SERVED PLAN	INDIVIDUALS SERVED ACTUAL	PERCENT ACCOMPLISHED
Adams County	$236,051	$154,152	20.6	16.4	161	141	87.5
Arapahoe County	117,200	102,784	17.6	20.0	101	112	110.9
Boulder County	105,626	145,590	10.8	18.0	83	125	150.6
Denver County	166,000	111,732	2.9	2.4	180	162	90.0
El Paso/Colorado Springs	365,126	284,523	24.6	21.7	293	322	109.9
Jefferson County	111,414	31,297	10.9	3.4	60	42	70.0
Larimer County	111,492	56,259	23.3	14.2	73	65	89.0
Pueblo County	99,891	46,526	8.6	4.4	96	65	67.7
Weld County	65,000	43,476	14.1	10.2	55	71	129.1
Balance of State	783,855	773,907	16.9	17.6	674	614	91.1
TOTAL	$2,161,655	$1,750,146		80.9	1776	1719	97.0

SUMMARY BY PRIME SPONSOR AREA OF TITLE I,
COMPREHENSIVE MANPOWER PLANS, FY 76

PUBLIC SERVICE EMPLOYMENT

TABLE IV

PROGRAM ACTIVITY	EXPENDITURES PLAN	EXPENDITURES ACTUAL	% OF SPONSORS FUNDS PLAN	% OF SPONSORS FUNDS ACTUAL	INDIVIDUALS SERVED PLAN	INDIVIDUALS SERVED ACTUAL	PERCENT ACCOMPLISHED
Adams County	$ 50,185	$ 60,100	4.2	6.5	20	20	100
Arapahoe County	3,944	3,944	6.6	1.0	57	57	100
Boulder County	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Denver County	-0-	-0-	-0-	-0-	-0-	-0-	-0-
El Paso/Colorado Springs	267,374	239,936	17.9	18.3	189	93	49.2
Jefferson County	259,610	363,185	23.5	39.5	25	94	376.0
Larimer County	113,958	108,157	23.8	27.3	30	30	100
Pueblo County	612,882	585,644	53.3	54.6	135	196	145
Weld County	208,343	236,442	45.1	55.5	30	85	283.3
Balance of State	1,198,837	1,054,979	25.9	24.0	425	431	101.4
TOTAL	$2,715,133	$2,652,387			911	1006	110.4

SUMMARY BY PRIME SPONSOR AREA OF TITLE I
COMPREHENSIVE MANPOWER PLANS, FY 76

WORK EXPERIENCE

TABLE V

PROGRAM ACTIVITY	EXPENDITURES PLAN	EXPENDITURES ACTUAL	% OF SPONSORS FUNDS PLAN	% OF SPONSORS FUNDS ACTUAL	INDIVIDUALS SERVED PLAN	INDIVIDUALS SERVED ACTUAL	PERCENT ACCOMPLISHED
Adams County	$ 238,253	$ 231,660	20.8	24.7	617	831	134.7
Arapahoe County	305,304	251,349	51.3	49.0	195	238	122.0
Boulder County	214,808	156,189	22.0	18.0	252	241	95.6
Denver County	564,900	533,967	10.1	12.0	420	546	130.0
El Paso/Colorado Springs	200,999	190,537	13.5	14.5	256	270	105.5
Jefferson County	134,705	75,933	12.2	8.4	150	114	76.0
Larimer County	116,690	126,457	24.3	31.9	295	239	81.0
Pueblo County	17,804	29,557	1.5	2.8	24	40	166.7
Weld County	76,416	39,930	16.5	9.5	189	176	93.1
Balance of State	1,337,166	2,928,240	25.9	29.6	1200	1428	119.4
TOTAL	$3,207,045	$2,928,819		90.1	2554	4123	161.4

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FINANCIAL SUMMARY BY PRIME SPONSOR

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TABLE VI

ACTUAL ACCRUED EXPENDITURES

TITLE I	TOTAL FUNDS*	TOTAL	Administration	% Admin.	Allowances	Wages	Fringe Benefits	Training	Services
Adams County	$ 1,157,186	$ 935,467	$ 133,980	14	$ 274,317	$ 225,982	$ 18,046	$ 124,556	$ 158,586
Arapahoe County	556,404	512,674	111,543	22	-0-	209,988	9,339	77,495	104,249
Boulder County	974,730	863,999	135,312	16	210,540	120,390	8,906	182,626	206,225
Denver County	6,560,161	4,489,817	1,260,969	28	978,600	351,260	11,490	251,009	1,636,489
El Paso/Colo Spgs.	2,663,168	1,310,984	254,387	19	243,407	331,047	19,767	222,479	239,897
Jefferson County	N/A	917,909	185,384	20	140,175	326,728	23,674	35,586	206,362
Larimer County	N/A	396,155	66,530	17	48,951	191,779	11,371	47,484	40
Pueblo County	1,071,693	1,071,085	165,405	15	141,471	456,544	67,571	137,568	102,526
Weld County	N/A	425,266	81,833	19	61,527	209,610	9,812	34,539	27,945
Balance of State	4,484,775	4,377,615	866,768	20	312,998	1,960,295	146,738	437,630	653,186
TOTAL	$17,468,117	$15,300,971	$3,262,111		$2,441,986	$,383,623	$326,774	$1,550,972	$3,336,505

N/A - Not Available

* Includes FY75 carry-in and FY76 allocations

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR
TITLE I, FY76 (JULY 1, 1975 - SEPTEMBER 30, 1976)

TABLE VII

TITLE I	Individuals Served Plan	Individuals Served Actual	% Of Plan Accom.	Age Groups 18 & Under	19-21	22-24	45-54	55-64	65 & Over	Entering Unsubdzd. Emplmt.
Adams County	1655	1639	99%	905	249	435	29	16	5	547
Arapahoe County	759	1061	140	246	276	485	39	14	1	375
Balance of State	4175	5168	124	1438	1049	2151	332	153	45	1884
Boulder County	762	895	117	189	167	504	26	9	0	439
Denver County	3720	4606	124	803	1179	2485	119	18	2	2576
El Paso/Colorado Springs	2464	2869	116	451	497	1685	182	47	7	1819
Jefferson County	900	904	100	109	184	522	62	26	1	583
Larimer County	648	605	92	226	80	229	35	21	14	205
Pueblo County	484	650	134	25	133	430	49	12	1	164
Weld County	552	626	113	203	117	271	26	8	1	224
TOTAL	16129	19023		4595	3931	9197	899	324	77	8816

of 19,023, 324 were over 55
899 between 45-54

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR
TITLE I, FY76 (JULY 1, 1975 - SEPTEMBER 30, 1976)

TABLE VIII

TITLE I (cont.)	Race and Ethnic Groups White	Black	Amer. Indian	Other	Special Target Groups* Spanish Amer.	Limited English	Migrant or Seasonal	Veterans Vietnam	Veterans Other	SEX Male	Female	Total
Adams County	1514	72	28	25	852	86	14	24	107	908	731	1639
Arapahoe County	875	66	13	107	88	76	5	44	38	500	561	1061
Balance of State	4951	33	150	34	2018	300	199	529	24	3109	2059	5268
Boulder County	631	33	22	209	279	37	55	32	58	380	515	895
Denver County	2118	1814	52	622	2170	57	8	156	334	2332	2274	4606
El Paso/Colorado Springs	2214	548	32	75	586	13	7	423	191	1339	1530	2869
Jefferson County	840	11	5	48	75	31	0	73	71	473	431	904
Larimer County	588	4	9	4	185	6	1	57	59	319	286	605
Pueblo County	597	37	6	10	400	0	5	91	34	343	307	650
Weld County	613	3	4	6	310	60	44	53	74	342	284	626
TOTAL	14967	2626	324	1160	6963	666	328	1482	990	10045	8978	19023

* Special Target Groups are not mutually exclusive.
Therefore, their total does not equal the total persons served.

TITLE III

Colorado's Special Program for Economically Disadvantaged Youth (SPEDY) provided 8,201 summer jobs with an allocation of $4,347,697 in special Title III funds.

A comparison of Colorado's participants characteristics and that of the United States, as a whole, shows that Colorado closely followed the nation in an equitable distribution of services to males (53%) and females (47%) and that educational levels of Colorado's participants did not deviate significantly from those served throughout the United States.

Three percent more AFDC recipients were served than nationally, as well as six percent more public assistance recipients. Thus, a greater proportion of Colorado's participants were among the most severely disadvantaged. In addition, fourteen percent of the SPEDY participants were black and fourty-four percent were of Spanish American heritage, reflecting the much higher unemployment rate among black and chicano youth in the State of Colorado.

Characteristics of SPEDY Participants
(Summer Program for Economically Disadvantaged Youth)
U.S. and Colorado
Fiscal Year 1976

(percent distribution)

	U.S.	Colorado
Total	933,000	8201
percent	100	100
Male	54	53
Female	46	47
Education.		
8 years and under	16	21
9-11	67	69
12	12	6
over 12	5	4
Family Income		
AFDC	27	30
Public Assistance	15	21
Economically Disadvantaged	96	88
Ethnic Group		
White	43	66
Black	49	14
American Indian	2	2
Other	6	18
Spanish American	13	44
Limited English	2	6
Handicapped	2	1
Full-time Student	88	92

TITLE II

A total of $1,597,527 was available to the Sate of Colorado for the operation of its Title II public service employment program. This total includes an FY-76 base allocation of $291,396, plus available Fy-75 funds totaling $36,769.

Of the 2,197 persons who participated in Title II programs statewide, 315 successfully entered unsubsidized employment. Tables IX and X summarize participant characteristics by prime sponsor.

TITLE VI

With a total funding of $8,408,995 for the State of Colorado in Fy75, 3,908 individuals participated in Title VI public service employment programs as of the end of the fifth quarter. Of these participants, 943 successfully entered unsubsidized employment. Tables XI and XII summarize the characteristics of these participants.

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR

TITLE II

Prime Sponsor TITLE II	Individuals Served Plan	Actual	% Of Plan Accom.	Age Groups 18 & Under	19-21	22-44	45-54	55-64	65 & Over	Entering Unsubdzd. Emplmt.
Adams County	295	194	66	9	17	147	13	8	0	30
Arapahoe County	63	85	134	12	7	27	0	12	27	2
Balance of State	435	405	93	25	75	259	32	12	2	92
Boulder County	100	93	93	5	3	83	2	0	0	18
Denver County	767	684	89	47	158	434	39	6	0	42
El Paso/Colorado Springs	310	328	106	5	37	266	15	5	0	60
Jefferson County	100	97	97	3	9	73	10	2	0	39
Larimer County	99	101	102	2	10	75	10	4	0	14
Pueblo County	157	158	101	4	23	121	9	1	0	13
Weld County	42	52	124	0	4	35	1	5	7	5
TOTAL	2368	2197		112	343	1520	131	55	36	315

1073

of 2,197 - 55 over 55
131 45-54
186

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR

TITLE II

Prime Sponsor TITLE II	Race and Ethnic Groups White	Black	Amer. Indian	Other	Spanish Amer.	Special Target Groups* Limited English	Migrant or Seasonal	Veterans Vietnam	Veterans Other	SEX Male	Female	Total
Adams County	183	7	0	4	47	2	0	14	34	100	94	194
Arapahoe County	67	5	3	10	10	2	0	0	7	44	41	85
Balance of State	297	0	4	4	118	22	4	34	77	232	173	405
Boulder County	80	4	1	8	12	0	0	16	9	54	39	93
Denver County	296	237	13	136	261	7	0	43	111	368	316	684
El Paso/Colorado Springs	261	60	2	5	52	0	0	72	28	181	147	328
Jefferson County	91	3	2	1	2	1	0	9	17	57	40	97
Larimer County	98	1	1	1	28	0	9	9	23	57	44	101
Pueblo County	145	8	1	4	104	0	1	16	12	90	68	158
Weld County	51	0	1	0	8	2	1	6	9	28	24	52
TOTAL	1669	325	28	175	642	36	6	219	327	1211	986	2197

* Special Target Groups are not mutually exclusive.
Therefore, their total does not equal the total persons served.

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR

TITLE VI

Prime Sponsor TITLE VI	Individuals Served Plan	Individuals Served Actual	% Of Plan Accom.	Age Groups 18 & Under	19-21	22-44	45-54	55-64	65 & Over	Entering Unsubdzd. Emplmt.
Adams County	250	257	103	9	26	199	16	7	0	57
Arapahoe County	209	204	97	48	41	94	13	7	1	82
Balance of State	750	806	107	41	135	551	60	16	3	301
Boulder County	166	173	104	4	9	154	6	0	0	43
Denver County	717	779	109	49	152	533	43	11	1	162
El Paso/Colorado Springs	327	353	108	3	36	284	22	8	0	148
Jefferson County	150	170	113	1	17	122	18	12	0	47
Larimer County	100	119	119	9	13	86	11	0	0	60
Pueblo County	124	140	113	2	23	108	7	0	0	32
Weld County	44	97	220	4	21	54	2	9	7	11
TOTAL	2837	3098		170	463	2185	198	70	12	943

of 3,098 - 70 over 55
- 198 between 45-54

CHARACTERISTICS OF PERSONS SERVED
SUMMARY BY PRIME SPONSOR

TITLE VI

Prime Sponsor TITLE VI	Race and Ethnic Groups White	Black	Amer. Indian	Other	Spanish Amer.	Special Target Groups* Limited English	Migrant or Seasonal	Veterans Vietnam	Veterans Other	SEX Male	Female	Total
Adams County	243	9	1	4	53	2	0	6	54	121	136	257
Arapahoe County	178	7	7	12	7	5	0	4	18	107	97	204
Balance of State	788	5	7	6	211	13	22	89	174	477	329	806
Boulder County	139	6	8	20	26	2	1	27	36	109	64	173
Denver County	389	221	13	156	252	6	0	70	138	442	337	779
El Paso/Colorado Springs	289	57	3	4	58	1	0	89	36	225	128	353
Jefferson County	162	4	3	1	5	1	0	22	51	114	56	170
Larimer County	118	1	0	0	25	0	0	14	20	55	64	119
Pueblo County	125	11	2	2	79	0	1	21	13	73	67	140
Weld County	95	1	0	1	30	5	4	4	9	48	49	97
TOTAL	2526	336	44	206	746	35	28	346	549	1771	1327	3098

* Special Target Groups are not mutually exclusive.
Therefore, their total does not equal the total persons served.

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
DIVISION OF EMPLOYMENT & TRAINING

The Wagner Peyser Act of 1933 provided for a cooperative National and State employment system. Insuing State legislation created a Statewide Employment Service and an Unemployment Insurance program. Under the Administrative Organization Act of 1968 a Department of Labor and Employment was created and the Division of Employment was established within the Department to operate the Employment Service and Unemployment Insurance program.

In 1976 the Division of Employment was renamed the Division of Employment and Training charged with administering the Governor's prime sponsorship for the Balance-of-State CETA program, as well as the Employment Service.

The major function of the Division of Employment and Training, as applied to the Employment Service Program, is to maintain free Job Service (JS) Centers. Thirty nine JS Centers operate statewide to provide a variety of employment services to job seekers and employers. (See attachment 1) Special emphasis is given to the economically disadvantaged, veteran and minority job seeker. Four Employment Service Area Offices located in Denver, Greeley, Pueblo and Grand Junction provide decentralized administration and management of JS Centers within their jurisdiction. (See attachment 1)

During the first nine months of FY 76 the Colorado JS Centers registered 166,264 job seekers and placed 27,464 of the same in non-agricultural jobs. Attachments 2,3, and 4 provide more information by Employment Service Areas on selected services and clientel.

SPECIAL EMPLOYMENT SERVICE ACTIVITIES

Services to Veterans

The Division of Employment & Training supervises and administers services to veterans as mandated by Federal laws and regulations. All Veterans, particularly disabled and Vietnam Era Veterans are provided the highest priority in referral and selection to jobs, counseling, manpower training and other relevant manpower services. Through the State Coordinator of Veterans' Services and the four Area Office Veterans' representatives the Chief of Employment Service Operation's functionally supervises the services to Veterans' Program coordinating with the Area Office Managers, Job Service Managers, Local Veterans' Employment Representatives and the State Staff. During FY 76 the Division of Employment & Training (DET) received a special grant to hire veterans to assist in enhancing services to all applicants, including veterans. A total of 24 temporary positions were filled under this contract.

Services to Disadvantaged Youth

Title IV of the CETA Act established a Job Corps Program for low income and disadvantaged youth. Job Corps provides residential and non-residential centers, nationwide, in which enrollees receive and intensive program of education, training, work experience, rehabilitation and counseling to facilitate citizenship and employability.

In Colorado, the Division of Employment and Training is funded to provide staff to recruit and enroll youth into the program. During FY 76 there were 1,023 youth enrolled by the Department of Employment and Training staff and 503 enrollees were placed in employment. The staff received an "Outstanding Performance Award" for exceeding the FY 76 planned enrollment goal. Colorado continues to be among the highest states in placement of returning Job Corps youth in jobs, further education and the Armed Services. A Nationally administered Residential Job Corps Center is located in Colbran, Colorado. This Center houses approximately 200 youth and offers training in Heavy

Equipment Operation, Carpentry, Masonry, Painting and Cooking. One of the more significant work experience activities of Colbran Job Corps youth in FY 76 was the involvement of 30 Heavy Equipment students with the reclaimation of the Big Thompson Canyon after the Mid-summer flood. The students assisted in debris removal and road-grading.

Aid To Families With Dependent Children (AFDC)

WIN -- The purpose of WIN is to assist recipients of AFDC move from Welfare to economic independence via employment. The major focus of the WIN program is on job placement, but supportive services are available during participation in WIN. In Colorado, WIN is jointly administered by the Department of Labor & Employment, Division of Employment & Training and the Department of Social Services (DSS). The DSS provides supportive services to program participants which include child day care, transportation and housing services. The DET provides for the registration of AFDC recipients in the WIN program and employability and training services. During FY 76 30,764 AFDC recipients registered with the WIN program and 5,715 WIN registrants entered employment.

Services to Migrant & Seasonal Farmworkers

In efforts to comply with the Judge Richey Court Order, the Colorado Division of Employment & Training has promoted comprehensive services to Migrant & Seasonal farmworkers. These services enhance crew leader registration, wage surveys, random field checks, outreach & development of understanding & application of housing standards & regulations. The Colorado Division of Employment & Training also provides job referral, Manpower Service, Job Service Center staff and cooperative relationships with state groups, these services were begun in a comprehensive manner in FY 76.

The Colorado Division of Employment and Training's Plan of Action for FY 77 includes: 1) A request for supplemental federal funds to implement a comprehensive Migrant Seasonal Farmworker Program in Northern Colorado. 2) Funding of the Colorado Migrant Council for preparation of a newsletter which will inform and advise the migrant on Job Service supportive services and available programs and 3) Improvement and expansion of the Colorado Division of Employment & Training's FY 76 service goals.

ADVISORY STRUCTURE

Public involvement in the programs of the Division of Employment and Training is mandated by Title 8, Article 72 of the Colorado Employment Security Act, which provides for the creation of a State Advisory Council. The Statutory Advisory Council aids the Division in formulation of policy and the administration of the Act, and approves expenditures of the Unemployment Revenue Fund. The Council consists of four employer representatives, four employee representatives and three representatives of the general public, who are appointed by the Governor of the State of Colorado for a term of four years. In addition, four employment Service Area Offices with "bottoms-up" planning of Employment Service program goals by providing community input to management.

The Balance-of-State CETA operation, lodged within the Division of Employment and Training, Training Services Section, also has its own advising system as regulated by CETA legislation. This separate advisory system includes three area subcouncils namely, the Northern Area Council, Southern Area Council and the Western Area Council.

Inasmuch as the Colorado Division of Employment & Training is relating to two separate advisory systems it is the objective of the Division in FY 77 to consolidate the Employment Service Area and CETA Area Councils. The ultimate result would be four advisory bodies representing the Denver area, Northern, Southern and the Western sections of the State, who will address both Employment Serivce and CETA issues.

LINKAGES

The CETA Prime Sponsors can utilize certain services provided by the Colorado Division of Employment & Training at no cost to the Prime Sponsor or to the CETA participants. The services they provide are:

Registration for Employment
Job Information
Selection & Referral to Job Openings
Coordination of Employer Contacts
General Labor Market Information

Depending on the extent of services required, the Prime Sponsor may reimburse the Colorado Division of Employment & Training to provide more intensive and extensive services. The following services are available under contract:

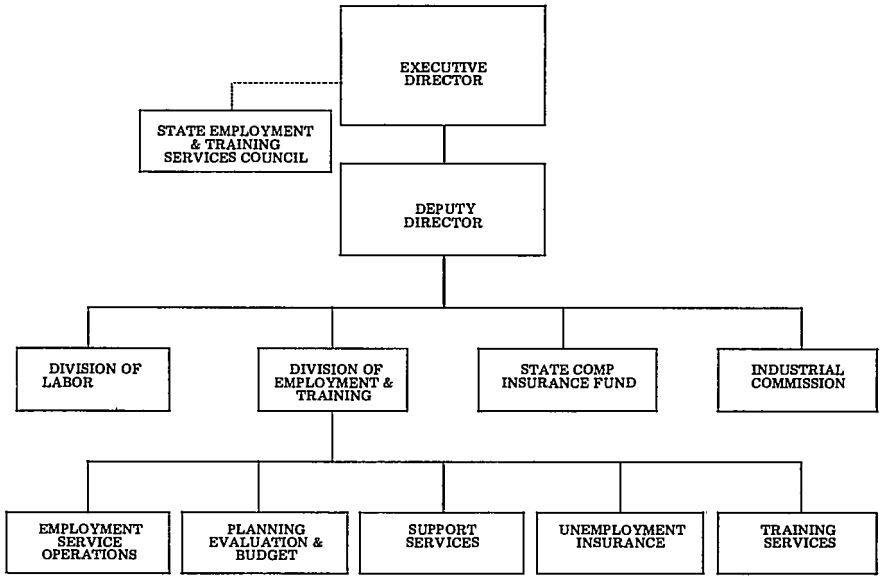
Outreach & Orientation
Employment Counseling & Testing
Job Search Assistance & Development
Employability Development Planning
Referral to Supportive Services
Follow-up
Job Bank Access

During FY 77 the Colorado Division of Employment & Training contracted with the following Prime Sponsors to provide a variety of manpower services:

Balance-of-State
Adams County
Arapahoe County
City of Colorado Springs/El Paso County Consortium
City & County of Denver
Jefferson County
Larimer County

During FY 77 an attempt will be made to eliminate the duplication of services provided by CETA and the Colorado Division of Employment & Training. Special funding of the Colorado Division of Employment & Training will permit the colocation of the Denver Job Service Center, the Denver Manpower Administration (CETA), Job Corps and the Work Incentive (WIN) Program. In addition, the U.S. Department of Labor has funded a project to coordinate linkage of services between all Denver Metro Job Service Centers and CETA Programs. Another program, Computerized Job Match, will be used by (CDET), CETA, WIN and Job Corps for placement of clients in jobs.

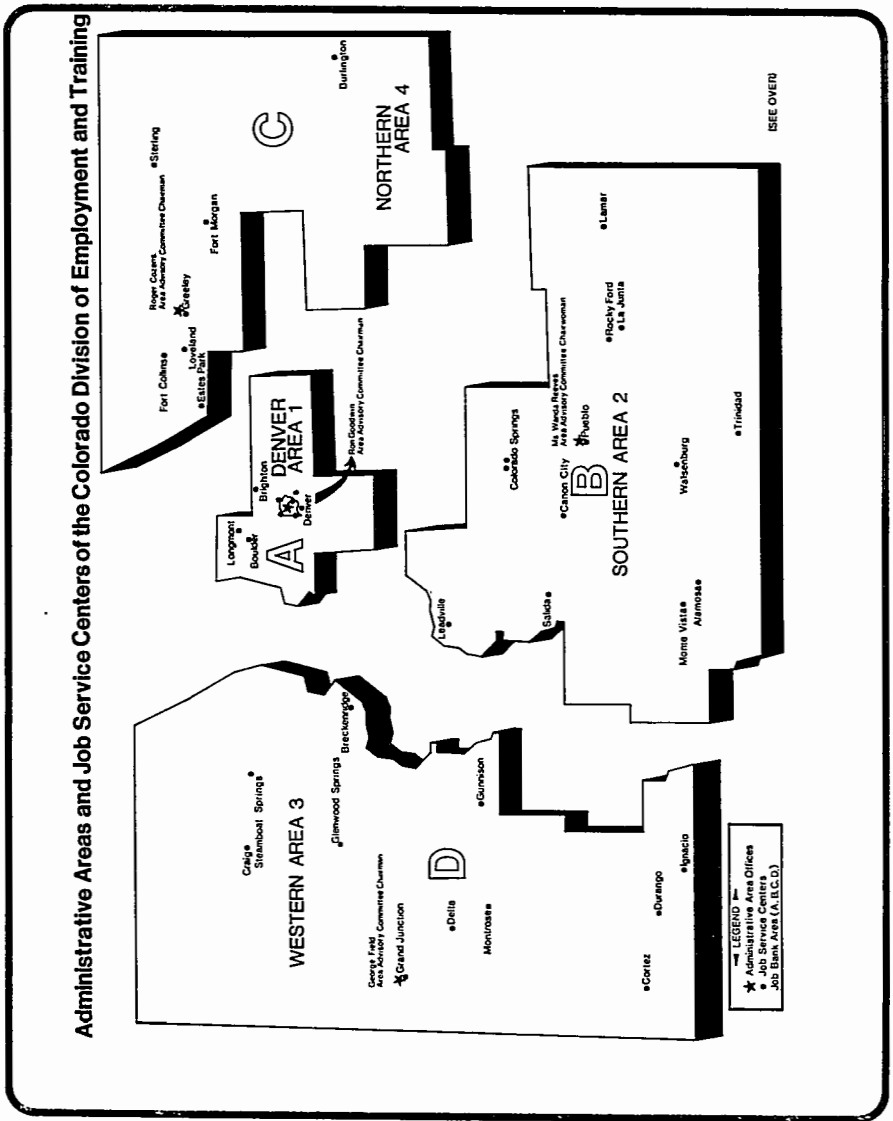
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT



ATTACHMENT 1

JOB SERVICE OF COLORADO

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
Division of Employment / 251 East Twelfth Avenue / Denver, Colorado 80203 / (303) 893-2400



PubInfo 5
(1/77)

DIRECTORY OF JOB SERVICE CENTERS

AREA ADMINISTRATIVE OFFICES

DENVER Area (1) — Edward W. Clark — 861-8865
835 East 18th Avenue
Denver, 80218

WESTERN Area (3) — John W. Porter — 243-4752
Valley Federal Plaza - Suite 301
5th & Rood Avenue - Grand Junction 81501

SOUTHERN Area (2) — Richard N. Lane — 544-1972
701 Court Street
Pueblo, 81003

NORTHERN Area (4) — Densil B. Connor — 353-6210, Ext. 225
805 - 20th Avenue
Greeley 80631 (Mail to P.O. Box 1870)

ALAMOSA (2) — Rudolph E. Gonzales — 589-6631
1560 - 12th Street 81101

BOULDER (1) — Harold Brecht — 443-6300
2950 Walnut Street
(Mail to P.O. Box 2170 80306)

BRECKENRIDGE (3) — Alfred D. Washburn — 453-2706
107 East Lincoln Avenue
(Mail to Box 1673 80424)

BRIGHTON (1) — Joe Garcia — 659-4250
27 South 4th Avenue 80601

BURLINGTON (4) — Miller W. Kelley — 346-7797
189 - 14th Street 80807

CANON CITY (2) — H. Grady Allen — 275-7408
410 Macon Avenue
(Mail to P.O. Box 150 81212)

COLORADO SPRINGS (2)

Downtown — Hoyte G. Williams — 473-6220
17 North Spruce Street

East — 473-6220
1701 North Academy Boulevard 80909
(Mail to P.O. Box 2200 80901)

CORTEZ (3) — Norman C. Schulz — 565-3759
490 West Main Street
(Mail to P.O. Box 790 81321)

CRAIG (3) — Albert Huber — 824-3246
316 West Victory Way 81626

DELTA (3) — Thomas Keenan — 874-7588
464 Main Street 81416

DENVER (1)

Downtown — Nelson Pingree — 893-2400, Ext. 254
600 Grant Street 80203

Aurora — Mildred Orendorff — 364-9111
10290 East Colfax Avenue - Aurora
80010

Englewood — Dick George — 761-8693
3311 South Broadway - Englewood
80110

Lakewood — F. Hugh Shovlin — 237-7791
8585 West 14th Avenue - Lakewood
80215

Westminster — Joseph A. Lindsey — 426-0503
7475 Dakin Street - Denver
80221

DURANGO (3) — Douglas O. Personeus — 247-0308
109 West 19th Street 81301

ESTES PARK (4) — Robert L. Wood — 586-4264
170 McGregor Avenue
(Mail to P.O. Box 1910 80522)

FORT COLLINS (4) — E. A. Engemoen — 493-2390
300 East Oak Street
(Mail to P.O. Box 2165 80522)

FORT MORGAN (4) — Leon Hamilton — 867-9401
311 Ensign Street 80701

GLENWOOD SPRINGS (3) — Jack Dalton — 945-8638
107 Village Plaza 81601

GRAND JUNCTION (3) — Robert M. Corcoran — 243-9990
634 Main Street 81501

GREELEY (4) — Joe D. Andrade — 353-6210
2004 Eighth Street
(Mail to P.O. Box 1226 80631)

GUNNISON (3) — Tim Devereux — 641-0031
307 North Main Street 81230

IGNACIO (3) — Houston Green — 563-4303
Box 555 - Ignacio 81137

LA JUNTA (2) — William N. Ward, Jr. — 384-7713
23 West 4th Street 81050

LAMAR (2) — Den Kusaka — 336-2256
103 East Elm Street 81052

LEADVILLE (3) — Alfred D. Washburn — 486-0765
Bank Annex Building 80461

LONGMONT (1) — Kenneth Thomas — 776-1921
1120 Main Street 80501

LOVELAND (4) — Robert L. Wood — 667-4261
418 East 4th Street
(Mail to P.O. Box 721 80537)

MONTE VISTA (2) — Rufus McMullen — 852-5171
39 Washington Street 81144

MONTROSE (3) — Donald Golladay — 249-7783
614 Main Street 81401

PUEBLO (2) — George J. Leonard — 544-1972
701 Court Street 81003

ROCKY FORD (2) — Robert L. Adcock — 254-3397
959 Elm Avenue 81067

SALIDA (2) — Edward L. Mitchell — 539-2841
151 West First Street 81201

STEAMBOAT SPRINGS (3) — Keith Lindsay — 879-3197
1107 Lincoln Avenue
(Mail to P.O. Box 9036 80471)

STERLING (4) — Miller W. Kelley — 522-5770
Student Center Building
Northeastern Junior College
(Mail to P O. Box 527 80751)

TRINIDAD (2) — John J. George — 846-9221
309 North Commercial Street 81082

WALSENBURG (2) — John J. George — 738-2390
112 East Sixth Street 81089

SELECTED EMPLOYMENT SERIVCE STATISTICS

Area and Item	Total	Female	Economic Disadvantaged	Minority	Spanish Surname	Vietnam Veteran	Under 22	45 and Over
COLORADO								
New Applicants & Renewals	274,548	110,249	87,344	60,433	43,088	41,685	74,576	32,266
Counseling	17,665	8,698	11,923	6,448	4,497	2,693	4,353	2,187
Testing	10,538	6,301	3,437	2,388	1,626	1,160	3,491	898
Referral to Job - Non Ag	112,120	41,488	35,986	23,683	17,138	19,147	34,266	10,507
Placed - Non Ag	51,329	18,180	18,403	12,459	9,712	8,873	17,241	4,982
Placed over 150 Days	35,462	14,235	12,141	7,533	5,646	6,325	10,845	3,463
AREA ONE								
New Applicants & Renewals	137,575	54,113	40,692	29,937	17,148	21,773	32,767	16,633
Counseling	9,900	4,757	6,524	3,786	2,168	1,345	2,340	1,254
Testing	4,976	2,999	1,522	1,114	578	590	1,271	507
Referrals to Jobs - Non Ag	50,192	16,439	14,428	10,193	5,607	9,598	13,963	4,501
Placed - Non Ag	18,845	5,739	6,183	4,317	2,551	3,772	5,940	1,754
Placed over 150 Days	13,815	4,616	4,279	2,854	1,566	2,821	4,114	1,261
AREA TWO								
New Applicants & Renewals	66,871	28,286	25,209	19,856	16,77	11,144	20,510	8,290
Counseling	4,885	2,278	3,155	1,850	1,599	977	1,362	553
Testing	3,572	2,170	1,290	1,020	830	421	1,339	247
Referrals to Jobs - Non Ag	27,253	11,232	10,161	8,190	6,915	4,662	8,508	3,068
Placed - Non Ag	13,932	5,411	5,471	4,920	4,375	2,254	4,764	1,652
Placed Over 150 Days	9,022	4,056	3,421	2,666	2,320	1,571	2,679	1,068
AREA THREE								
New Applicants & Renewals	40,331	14,274	12,302	5,261	4,035	5,541	12,015	3,846
Counseling	1,279	677	843	266	193	227	245	200
Testing	1,313	665	459	182	151	106	704	80
Referral to Job - Non Ag	17,806	6,090	6,032	2,417	1,961	2,821	5,936	1,422
Placed - Non Ag	8,916	3,091	3,426	1,437	1,120	1,392	3,053	791
Placed over 150 Days	6,122	2,484	2,216	948	785	940	1,930	566
AREA FOUR								
New Applicants & Renewals	35,853	15,077	11,317	6,523	6,202	4,641	11,072	3,878
Counseling	1,667	1,013	1,450	571	554	156	426	185
Testing	695	481	222	73	67	44	186	64
Referrals to Job - Non Ag	19,260	8,171	6,234	3,233	3,057	2,742	6,547	1,697
Placed - Non Ag	10,009	3,980	3,485	1,852	1,767	1,582	3,592	831
Placed over 150 Days	6,620	3,104	2,257	1,052	998	1,038	2,160	581

Selected Demographic Characteristics
of Employment Security Applicants

	Total Applicants	Minority	Economically Disadvantaged
Age - Under 20	21,825	6,238	8,651
20-24	51,067	9,888	16,586
25-39	61,428	13,268	1,851
40-54	19,989	4,912	6,236
55 & over	7,594	1,672	2,261
Education 0-7	5,387	3,975	3,461
8-11	38,938	14,298	18,210
12	68,015	12,728	19,872
Over 12	49,563	4,977	10,709
Spanish Surname	25,641	25,641	13,317
Black		8,264	
Physically Handicapped	6,744	1,188	2,448
Economically Disadvantaged	52,252	18,515	
Food Stamps	20,647	6,556	12,004
Welfare	17,069	7,661	16,939
Employment Status			
Not working	147,418	32,907	48,415
Total	161,903	35,978	52,252

Source: ESAR's Tables D6, A06, B06
July 1, 1975 - March 31, 1976

of 161,903 - 7,594 are over 55

~~27,5~~ 27,500 are over 40

STATE SERVICES

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF REHABILITATION

The Soldiers Rehabilitation Act of 1918 and the Smith-Fess Act of 1920 established the precedent for rehabilitation programs. The primary purpose of the Smith-Fess Act was to encourage states to undertake legislation to provide rehabilitative services to disabled civilians. Insuing States and National legislation provided for establishment of a Division of Rehabilitation within the Colorado Department of Social Serivces.

The Division of Rehabilitation administers a combination of services provided to the physically and mentally handicapped for the purpose of preparing handicapped individuals to obtain a remunerative occupation. Eligibility for vocational rehabilitation (VR) services is based on the presence of a disability which for the individual results in a substantial handicap to employment and a reasonable expectation that VR services will benefit the individual in terms of employability. The following is a list of VR services available to individuals:

1. Evaluation of rehabilitation potential
2. Counseling, guidance and referral
3. Physical and mental restoration services
4. Vocational and other training services
5. Maintenance
6. Transportation
7. Services to members of a handicapped individual's family necessary to the adjustment or rehabilitation of the handicapped individual.
8. Interpreter services for the deaf.
9. Reader, teaching and orientation and mobility services for the blind.
10. Placement in suitable employment.
11. Telecommunications, sensory and other technological aids and devices.
12. Recruitment and training services to provide new employment opportunities.
13. Post employment services necessary to assist handicapped individuals to maintain suitable employment.
14. Occupational licenses, tools, equipment and initial stocks and supplies and
15. Other goods and services which can reasonably be expected to benefit a handicapped individual in terms of his employability.

Twenty seven District Offices operate statewide to provide Vocational Rehabilitation services. During FY 76 8,319 individuals were referred to the District Offices. Of those referred, 3,686 became active Rehabilitation cases, resulting in a total statewide caseload of 10,094. At the end of FY 76, 3,457 individuals were still enrolled in training or were receiving physical restoration services and 1,974 individuals had been employed for at least 60 days.

STATE BOARD FOR COMMUNITY COLLEGES AND OCCUPATIONAL EDUCATION

Federal assistance for vocational education dates from 1917, when the passage of the Smith-Hughes Act provided funding for vocational training in a limited number of occupational areas.

The Federal Vocational Education Act of 1963 made vocational education available to all persons, removed the restrictions on occupations of training and placed emphasis on helping people obtain employment.

During 1967 the Colorado State Board for Community Colleges and Occupational Education was created. This board included the funciton of the State Board for Vocational Education and for a state system of community colleges. In the implementation of the Community College System, heavy emphasis was placed on the development of vocational programs. Presently, enrollment in vocational programs in the Community College System exceeds fifty percent.

The major component of the Vocational Educational Programs provides for secondary, post-secondary and adult level programs. During the 1975 - 1976 school year 50, 150 students were enrolled in secondary level vocational programs, 46,969 were enrolled in the post-secondary programs, and 15,396 were enrolled in the Adult level vocational programs. The following table shows enrollments by program level and occupational area.

VOCATIONAL ENROLLMENT BY OCCUPATIONAL OBJECTIVE			
Occupational Objective	Secondary	Post-Secondary	Adult
Vocational Agriculture	4324	1257	1018
Distributive Education	5062	2183	1513
Health Occupations	919	6140	1576
Occupational Home Economics	2531	1139	2840
Business and Office Education	20978	14343	2511
Technical Education	2224	8816	1505
Trade and Industrial Education	12361	13003	4433
Other Special Education	1751	88	
TOTAL	50150	46969	15396

Although placement services are provided through the Vocational Education Programs, placement information for the 1975 - 1976 school year is not yet available. The following table lists information on students who graduated or terminated from vocational programs at the secondary and post-secondary level during the 1974 - 1975 school year. This information is displayed by percentages.

	PERCENTAGE				
	Employed in Area & Rel.	Employed Unrelated	Unemployed Seeking Employment	In School	Not Available or Unknown
SECONDARY					
Agriculture Education	50	13	3	20	14
Distributive Education	46	10	3	20	21
Health Occ. Ed.	38	10	3	20	29
Occupational Home Ec.	39	9	5	20	27
Business & Office Ed.	32	12	4	27	25
Technical Education	32	20	4	25	19
Trade and Industrial Occ.	39	18	4	15	24
POST-SECONDARY					
Agriculture Education	64	5	4	9	18
Distributive Education	70	7	2	6	15
Health Occ. Ed.	59	2	4	3	32
Occupational Home Ec.	65	2	3	3	27
Business & Office Ed.	50	7	4	6	33
Technical Education	62	8	2	7	21
Trade and Industrial Occ.	58	12	3	6	21

Information provided in this section on the State Board for Community Colleges and Occupational Education was extracted from the 7th Annual Report, 1976 Colorado Advisory Council for Vocational Education.

DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF LABOR APPRENTICESHIP COUNCIL

The Colorado Apprenticeship Council seeks voluntary co-operation of labor and management in the promotion of apprenticeship training programs and in the establishment of new apprenticeship training programs in the arts and crafts. The Council provides the means to recognize training programs which meet the fundamentals of apprenticeships and registration for individuals enrolled in registered apprenticeships. Persons completing a registered apprenticeship program are recognized throughout their industry as skilled with the knowledge and skills required for all-around proficiency.

During FY 76, 1977 persons were registered to apprenticeships and 635 persons were issued certificates of completion of apprenticeship. 63 new training programs met the criteria for and were registered as apprenticeships in the State of Colorado during this time.

OTHER MANPOWER ACTIVITIES

TITLES IX OLDER AMERICANS ACT

Title IX of the Older Americans Act (OAA) promotes useful part-time subsidized employment for unemployed, low income perosns who are fifty-five years and older. The Secretary of Labor enters into agreements with public or private non-profit agencies or organizations in order to further the goals of the Title IX employment program. National contractors providing employment opportunities for older Americans in Colorado are Seniors Inc., Green Thumb Inc. and the National Forest Service.

During FY 76 Seniors Inc., through the National Council of Senior Citizens was funded $329,000 to provide part-time subsidized employment for 60 older workers in Denver, and 29 older workers in Pueblo. All 89 positions were filled during the year and provided to the older person an approximate hourly wage of $2.45.

Green Thumb Inc. was funded $51,000 during FY 76 to provide subsidized employment for 14 older persons in the Trinidad and Walsenburg Area. As Green Thumb Inc. was new to Colorado in FY 76, program implementation was not accomplished until FY 77. Delay in program operation enabled 18 older persons to be placed in employment.

The U.S. Forest Service was funded $145,000 in FY 76 to provide part-time subsidized employment for older persons. During FY 76, 24 persons were employed at various statewide sites to provide work involved in resource improvement and conservation in the Colorado National Forest system. The average wage for older workers in the U.S. Forest Service program was $2.63 an hour.

TITLE X PUBLIC WORKS & ECONOMIC DEVELOPMENT ACT

During FY 76 Congress appropriated $375 million under the Job Opportunities Program- Public Law 93-567, Title X of the Public Works and Economic Development Act of 1965 for Public Service Employment. Title X monies were issued by Congress to the U.S Department of Commerce to stimulate the creation of jobs for unemployed persons in areas of high unemployment. Because the Department of Commerce had no mechanism for distributing these funds it designated other federal agencies and multi-state regional commissions as conduits for the money.

Two million, ninety five thousand dollars were designated to Colorado through the Department of Health, Education & Welfare, Department of Transportation, Community Services Administration, Four Corners Regional Commission and the Law Enforcement Assistance Administration.

The Denver Regional Office of the Law Enforcement Assistance Administration acted as conduit for $526,900 Title X funds from the U.S. Department of Commerce to the Colorado Department of Institutions to provide Public Service Employment within the state.

The objective of the Department of Institutions was to employ 80 persons from the unemployed population in full-time clerical positions in Colorado institutions.* Individuals selected for placement were to be clients of the Department of Institutions, unemployed at least two weeks and either handicapped, youth, minority, 45 years or older or male, looking for non-traditional employment. Five positions were slotted in Chaffee County, 47 in Denver County, 8 in Fremont County, 10 in Mesa County and 10 in Pueblo County. The majority of jobs were entry level clerical and paid about $517 per month.

The Department of Institutions exceeded their placement goal of 80 by 66 during the grant year. Of the 146 persons employed through the program 21.9% were handicapped, 29.5% were youth, 35.6% were minority, 41.1% were 45 years or older and 15.1% were males in non-traditional jobs. 43 of the 146 individuals obtained permanent employment through the institutions in which they had worked or by their own initiative. 26 of the 43 individuals that obtained employment became employed under the Colorado State Personnel System.

The Colorado Office of Human Resources (OHR) through the Community Services Administration (CSA) was granted $756,400 for manpower to be used in the Home Winterization Program. The Winterization Program provides materials to the poor but not labor or the cost of labor for winterizing a home. Under Title X the OHR was able to obtain the needed manpower for the effective emplementation of the Home Winterization Program and provide temportary employment and training to unemployed individuals.

Approximately 110 individuals were employed through the Office of Human Resources Title X program and provided a wage of $2.50 per hour. Supervisor/foreman employed for the project received not more than $700 a month.

* The State Home & Training Schools, the State Hospital at Pueblo, the State Penitentiary and the State Reformatories are some of the institutions administered by the Department of Institutions.