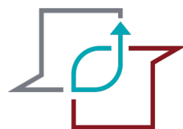
Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement

Interim Committee Update

July 18, 2023



POLICY COLLABORATIVE
FOR CHILDREN
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Background

Task Force Overview

Why are we here?

Timothy Montoya-Kloepfel thrived in the joy of others. He would do just about anything to make someone happy. If you said his Nerf gun was cool, it was yours. If you complemented his T-shirt, he would take it off and hand it to you. Timothy – Timmy to his mother and friends – reveled in painting pictures and creating items out of duct tape, all so he could give them to someone else. But as much as Timothy blossomed in the joy of others, he also wilted under the weight of the world's problems. He was overwhelmed at reports of shootings on national and local news stations. The burden of such events became so much that the then 10-year-old boy asked his mother: "What is it like to be depressed and what does that word mean?" That question was the start, the beginning of what Timothy's mother, Elizabeth Montoya, would call a "vicious cycle." During the next two years, Timothy would cycle in and out of short-term hospitalizations, residential child care facilities and in-home services. He would be diagnosed with autism, attention deficit hyperactivity disorder and post-traumatic stress disorder. He would repeatedly threaten to harm himself, and he kept running – running away from the people and systems trying to help him.

Timothy's needs were severe and qualified him for behavioral health treatment through Medicaid and other programs. But qualifying for these programs did not guarantee Timothy was receiving the services they offered. Timothy's mother struggled to find providers with the availability and/or willingness to take on his case. Receiving services through one program, often knocked Timothy out of another. These gaps in services could last days, or they could last months. During those gaps, Elizabeth recalls doing all she could for Timothy. One day this meant holding Timothy in a bearhug on the floor next to a window. For almost an hour, the then 11-year-old would alternate between telling his mother he loved her and lunging toward the open first-floor window.

Timothy had been successful during past placements in residential childcare facilities. So, his mother was hopeful when he was placed in a local facility during the summer of 2020. Her hopes were quickly shattered. Despite his history of running away, and unknown to his mother, Timothy was placed in a facility struggling to respond to youth who ran away. Just days after he was placed, Timothy ran from the unlocked facility. He was later walking on a dark road where he was hit by a car. Timothy died from his injuries. He was 12 years old.

Elizabeth does not blame the facility – or any singular entity – for her son's death. However, she knows that her son's life and death offer valuable lessons regarding how to improve the multiple systems that touched her child.

More than one year after her son's death, no one called Elizabeth to ask what could have been done better. Had they called, Elizabeth could have calmly and clearly articulated improvements to the child protection system that she believes would have helped her son while he was alive. But no one called her. "Shouldn't we all learn from this?" Elizabeth asked recently.

"All I want to do is make sure something changes for other kids."

In the spring of 2021, the Office of Colorado's Child Protection Ombudsman (CPO) was contacted by a community member who learned about Timothy's death and was concerned that the circumstances leading to his death would not be examined. The CPO reviewed Timothy's case and ultimately learned that Colorado lacks a sufficient infrastructure to deter youth from running away from out-of-home placements and to ensure their well-being when they return.

In the fall of 2021, the CPO started working with members of Colorado's General Assembly, Colorado's residential treatment provider community and other stakeholders to draft legislation aimed at addressing youth who run away from their out-of-home placement. This work culminated in the creation of House Bill 22-1375, "*Concerning Measures To Improve Outcomes For Those Placed in Out-of-Home Placement Facilities*." This bill established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-Of-Home Placement (Task Force).[1]

This critical task force is established to analyze the root causes of why children run away from out of home placement; develop a consistent, prompt, and effective response to recovering missing children and to address the safety and well-being of a child upon the child's return to out-of-home placement.

Overview of the Task Force

The Meeting Process

The Task Force will meet during the next two years and is required to produce two reports for the Colorado General Assembly. The first report is due October 1, 2023, and a final report is due October 1, 2024. The report will contain the Task Force's findings and any systemic recommendations made by the members. The meetings will be held virtually to ensure participation from stakeholders across the state.

Each meeting will be supported and facilitated by the Keystone Policy Center (Keystone). Keystone was established in 1975 and is an independent non-profit organization. They have helped public, private and civic-sector leaders solve complex problems and advance good public policy for more than 40 years in Colorado and nationally. Keystone does not advocate for any policy position but rather works to ensure that stakeholders share decision making and work together to find mutually agreeable solutions to complex problems.

Meeting Dates:

All Task Force meetings will be held virtually from 8 a.m. to 11 a.m. on the following dates:

- September 28, 2022
- November 2, 2022
- January 4, 2023
- March 1, 2023
- May 3, 2023
- July 5, 2023

[1] https://leg.colorado.gov/bills/hb22-1375

- September 6, 2023
- November 1, 2023
- January 3, 2024
- March 6, 2024
- May 1, 2024
- July 3, 2024
- September 4, 2024

Task Force Members and the Charge

The Task Force is comprised of 24 individuals from our community. These members include young people who previously resided in the child welfare system, families whose children have run from out-of-home placements, members of law enforcement and professionals who are responsible for the care of youth in out-of-home placements including residential child-care providers, child welfare human service providers, non-profit organizations, foster parents and others.

The Task Force is required to analyze:

- The sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placements;

- The root causes of why children run away from out-of-home placements;

- The differences between runaway behavior and age-appropriate behaviors;

- The behaviors that should lead a person or facility to file a missing person report about a child;

- The relationship between children who have run away from out-of-home placement and the likelihood that the child will become a victim of crime;

- The comprehensiveness and effectiveness of existing state laws and regulations, and placement facility protocols, to respond to a child who runs from an out-of-home placement—including a review of practices related to reporting, locating, evaluating, and treating children who have run away.

- The best practices statewide and nationally for preventing and addressing runaway behavior;

- How entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors; and

- Resources to improve or facilitate communication and coordinated efforts among out-of-home placement facilities, county departments of human or social services, and law enforcement agencies.

Support

Keystone will assist the Task Force by providing research, meeting support and assistance in generating final written reports.

The Task Force's work will also be supported by research from the Colorado Evaluation and Action Lab (Colorado Lab) at the University of Denver. This research institution will conduct focus groups with children in out-of-home placement and young adults who previously resided in the child welfare system. These focus groups will help the Task Force understand what conditions lead children to run away from out of home placement, opportunities and resources that could prevent youth from running away; and resources that youth need to ensure their safety and well-being after they return to out-of-home placement. The results of the focus groups will be provided to the Task Force to inform its finding and recommendations.

Task Force Members Responsibilities

Task Force members are expected to attend and participate in each meeting. Each member brings an important perspective, and we are eager to hear from all of you. If you are unable to attend a meeting, please provide advance notice to the Chair and we will ensure you are provided meeting minutes and updates.

Questions?

If you have any questions about the Task Force, please contact:

- **Berrick Abramson,** Senior Policy Director
  Keystone Policy Center
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  Phone: 970-760-0727

- **Trace Faust,** Senior Project Director
  Keystone Policy Center
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  Phone: 303-990-7422

- **Jordan Steffen,** Deputy Ombudsman
  Office of Colorado's Child Protection Ombudsman
  Email: jsteffen@coloradocpo.org
  Phone: 720-625-8645

ABOUT THE OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN
The Office of Colorado's Child Protection Ombudsman (CPO) is an independent state agency committed to ensuring the state's child protection system consistently provides high quality services to every child, family and community in Colorado. The CPO studies the child protection system to ensure a better future for Colorado's children and youth. By researching and highlighting issues within Colorado's publicly funded safety nets, the CPO is working create a better child protection system now and for the future.

Background

Legislative Charge

Timothy Montoya Task Force: Legislative Charge
HB 22-1375; CRS §19-3.3-111

(5) The task force shall:

(a) analyze the sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placement;

(b) analyze the root causes of why children run away from out-of-home placement;

(c) identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child;

(d) analyze the relationship between children who have run away from out-of-home placement and the likelihood that the child will become a victim of crime;

(e) analyze the comprehensiveness and effectiveness of existing state laws and regulations, and placement facility protocols, to respond to a child's threat to run away from out-of-home placement and for promptly reporting, locating, evaluating, and treating children who have run away;

(f) analyze best practices statewide and nationally for preventing and addressing runaway behavior, including identifying methods to deter children from running away from out-of-home placement;

(g) analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors;

(h) identify resources necessary to improve or facilitate communication and coordinated efforts related to children who run away from out-of-home placement among out-of-home placement facilities, county departments of human or social services, and law enforcement agencies; and

(i) at its discretion, develop recommendations to reduce the number of children who run away from out-of-home placement and include the recommendations in its reports described in subsection (7) of this section.

(6)(a) The institution of higher education shall conduct focus groups with children in out-of-home placement and young adults under twenty-two years of age who have aged out of the child protection system to assist the task force in fulfilling its duties. The institution shall conduct focus groups with out-of-home placement providers to determine what conditions lead children to run away from out-of-home placement, the provider's efforts to locate children who have run away, and the services provided to a runaway child upon the child's return.

(b) The institution of higher education shall ask each focus group to consider:

(i) the reasons why children run away from out-of-home placement;

(ii) opportunities and resources that could prevent children from running away from out-of-home placement; and

(iii) resources that children need to ensure their safety and well-being after they return to out-of-home placement.

(c) the office shall reimburse each focus group participant who is a child or youth for the participant's reasonable expenses incurred for participating in a focus group.

(d) the institution of higher education shall make information learned from the focus groups publicly available and shall submit its findings to the task force on or before April 1, 2023. Personally identifiable information about the persons who participated in a focus group is confidential and the institution shall not make public any personally identifiable information.

(7)(a) On or before October 1, 2023, the task force shall submit a first-year status report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the House of Representatives Public and Behavioral Health and Human Services Committee and the Senate Health and Human Services Committee, or their successor committees. The first-year status report must include a summary of the task force's work and the task force's initial findings and recommendations, if available.

(b) On or before October 1, 2024, the task force shall submit a final report to the governor, the president of the senate, the speaker of the house of representatives, and the house of representatives public and behavioral health and human services committee and the senate health and human services committee, or their successor committees, that includes a summary of the task force's work and the task force's recommendations, if applicable.

Background

Task Force Charter

Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement Task Force Charter

Introduction

In the spring of 2021, the Office of Colorado's Child Protection Ombudsman (CPO) was contacted by a community member who learned about Timothy Montoya's death after he ran from an unlocked residential childcare facility and was struck by a car. The community member was concerned that the circumstances leading to his death would not be examined. The CPO reviewed Timothy's case and ultimately learned that Colorado lacks sufficient infrastructure to deter youth from running away from out-of-home placements and to ensure their well-being when they return.

In the fall of 2021, the Office of Colorado's Child Protection Ombudsman (CPO) started working with members of the Colorados General Assembly, Colorado's residential treatment provider community and other stakeholders to draft legislation aimed at addressing youth who run away from their out-of-home placement. This work culminated in the creation of House Bill 22-1375, "Concerning Measures To Improve Outcomes For Those Placed in Out-of-Home Placement Facilities." This bill established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement (Task Force).

This Charter outlines the mission, scope and objectives of the Task Force along with its guidelines, media protocols and task force roles.

Mission

This critical task force is established to analyze the root causes of why children and youth run away from out-of-home placement, develop a consistent, prompt and effective response for when children or youth run away from out-of-home placements and to recovering missing children and to address the safety and well-being of a child or youth upon their return to out-of-home placement.

Charge

Pursuant to HB 22-1375, the Task Force is required to analyze:

- The sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placements;
- The root causes of why children run away from out-of-home placements;
- The differences between runaway behavior and age-appropriate behaviors;
- The behaviors that should lead a person or facility to file a missing person report about a child;
- The relationship between children who have run away from out-of-home placement and the likelihood that the child will become a victim of crime;

- The comprehensiveness and effectiveness of existing state laws and regulations, and placement facility protocols, to respond to a child who runs from an out-of-home placement — including a review of practices related to reporting, locating, evaluating, and treating children who have run away;
- The best practices statewide and nationally for preventing and addressing runaway behavior;
- How entities responsible for the care of children who run away from out-of home placement can coordinate a thorough and consistent response to runaway behaviors; and
- Resources to improve or facilitate communication and coordinated efforts among out-of-home placement facilities, county departments of human or social services, and law enforcement agencies.

Definitions (see other sections for more detailed descriptions):

- **Members:** The Task Force is composed of 24 individuals from our community. These members include young people who were previously involved with the child welfare system, families whose children have run from out-of-home placements, members of law enforcement and professionals who are responsible for the care of youth in out-of-home placements, including residential child-care providers, child welfare professionals, non-profit organizations, foster parents and others.
- **Factiliation Team:** Each meeting will be supported and facilitated by the Keystone Policy Center (Keystone). Keystone was established in 1975 and is an independent non-profit organization. They have helped public, private and civic-sector leaders solve complex problems and advance good public policy for more than 40 years in Colorado and nationally. Keystone does not advocate for any policy position but rather works to ensure that stakeholders share decision making and work together to find mutually agreeable solutions to complex problems.
- **Co-Chairs:** Co-chairs of the Task Force will serve in an advisory role to Keystone, between meetings to assist with assessing progress and setting agendas for Task Force discussions. They will be available to members to provide feedback and guidance.
- **Work Groups:** Forums composed of members and implementing partners that are focused on coordinating and aligning efforts in executing official and endorsed projects of the task force.

Task Force Outcomes

Per HB 22-1375, the Task Force must submit a first year status report and a final report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the House Public & Behavioral Health & Human Services and the Senate Health & Human Services. The first-year status report must be submitted by October 1, 2023, and the final report must be submitted by October 1, 2024. The CPO will also broadly disseminate the report to the public and members of the media.

Both reports will contain a summary of the Task Forces analysis of each directive listed above. The reports will recognize any points of consensus reached by the Task Force, as well as any differing opinions or perspectives. It is important to note that consensus is not required for any discussion to be presented in the report.

Pursuant to its enabling statute, the Task Force may issue recommendations, but it is not required to do so. The Task Force may discuss whether a recommendation is necessary to address any of the directives above.

Keystone is responsible for facilitation and project management, as it relates to the activities of the Task Force. Keystone is responsible for co-designing the process with the CPO office and co-chairs and ensuring the Task Force runs smoothly, including promoting full participation of all Task Force members and -- when possible -- helping the parties resolve their differences and work toward resolving concerns. Working with task force members, Keystone will ensure adequate and coordinated stakeholder engagement that will be essential to the task force meeting its goals. Keystone staff will also be available to consult confidentially with participants during and between meetings.

Ground Rules

- **GOOD FAITH**: Act in good faith in all aspects of group deliberations with the intent to promote joint problem solving, collaboration and collective, common-ground solutions; honor prior agreements including but not limited to the contents of this Charter.
- **OWNERSHIP**: Take ownership in the outcomes and the success of the Task Force.
- **OPENNESS**: Be honest and open in sharing your perspectives; be open to other points of view and to the outcome of discussions.
- **FOCUS**: Maintain focus on the mission and goals of the Task Force as well meeting objectives; honor agendas.
- **LISTENING**: Listen to each speaker rather than preparing your response; no interruptions; refrain from multitasking during meetings.
- **PARTICIPATION**: Participate actively, ensuring that your experience and voice is included in the discussion. Make space for others to speak. Be mindful and respectful of the presence of multiple backgrounds and areas of expertise and avoid the use of acronyms and technical language from your field.
- **RESPECT**: Disagree judiciously and without being disagreeable; do not engage in personal attacks; in all contexts, refrain from behavior that denigrates other participants or is disruptive to the work of the group.
- **PREPAREDNESS AND COMMITMENT**: Prepare for and attend each session; get up to speed if you missed a meeting.
- **FACILITATION AND CONFLICT RESOLUTION:** Let the facilitators facilitate; allow them to enforce the ground rules and engage them with any concerns.

Media Protocols

Media protocols are provided to ensure that Task Force members utilize consistent messages and processes when communicating about the Task Force and that individual members' interests are protected through the accurate characterization of their association with the Task Force.

- Only use messaging that has been agreed upon by the Task Force and approved by Keystone when characterizing the Task Force on behalf of its members, and when characterizing the roles and commitments of members.
- Be clear to delineate your own opinion or interest from the agreed-upon messaging of the Task Force.
- Do not characterize or attribute the opinions or positions of other members.
- Press releases of/on behalf of the Task Force will be reviewed by the CPO prior to their release. CPO will coordinate the development, review and submission of media releases with the Task Force under a timely process.
- Individual members should not make announcements on behalf of the Task Force. Members planning their own media releases and/or other formal communications that reference or characterize the Task Force – including but not limited to web copy and presentations – should submit the draft materials to Keystone for review at least one week prior to the intended public release date. Keystone will review the materials for consistency with agreed-upon messaging and, where necessary, coordinate with task force members for further review.

If you receive a media inquiry, you are encouraged to coordinate with Keystone prior to providing answers to interview questions. You may also feel free to refer the inquiry directly to Keystone.

Meeting 1 – Sept. 28, 2022

Agenda

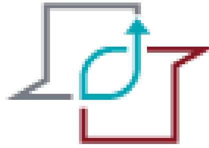
Timothy Montoya Task Force | Kick-Off Meeting
September 28, 2022, 8am-11am
Virtual - Zoom
Facilitator: Keystone Policy Center (Trace Faust, Christine Scanlan)

Materials Folder

Time	Agenda Topic	Facilitator / Presenter
8:00am	Opening & Introductions	Stephanie Villafuerte, Keystone Policy Center
9:00am	Timothy's story	Elizabeth Montoya
9:15am	Panel Discussion - Provider Experience • Q&A	Brandon Miller, Erin Henderson, Samantha Buck, Trace Faust (moderator)
9:45am	Panel Discussion - Lived Experience • Q&A	Dominique Mallard, Tamisha Macklin, Trace Faust (moderator)
10:15-10:25am	Break	
10:30am	Overview focus groups	Stephanie Villafuerte, Kristin Klopfenstein, Kristin Myers
10:40am	Public Comment	
10:50am	Closing	Stephanie Villafuerte, Keystone Policy Center

Meeting 1 – Sept. 28, 2022

Minutes



POLICY COLLABORATIVE
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Meeting Minutes - Timothy Montoya Task Force

November 2, 2022 | 8am-11am

Recording

Facilitators: Keystone Policy Center

Time	Agenda Topic and Notes	Facilitator/Presenter
8:00 am	Opening & Welcome ● Berrick Abramson from Keystone encouraged participation with the survey sent out to task force members	Stephanie Villafuerte
8:10-8:45 am	*September Meeting Reflections* ● *What were your biggest takeaways or "a-ha" moments and how is it informing how you come to this task force's work?*	Keystone

From Task Force:

- Hearing a lot about experiences from youth but not much about their accessing or awareness of services both for themselves and their families.
- Appreciation for Beth Montoya's willingness to share her story and how that should inspire everyone. Listening to the providers regarding policy/rule/statute that gets in the way of intervening with kids running away. The task force needs to understand if there are opportunities for change or recommendations to make.
- Appreciation for the diversity of the youth & their experiences.

- Services were only available after commitment which came with lifetime consequences despite her asking/wanting services. Not being heard led to bad actions. We need a deeper understanding of what's available and the process to access
- Concern shared about overall terminology and particularly the word "runaway" feels loaded. The word is used because it's included in the language of laws written, task force member suggested maybe exploring the language piece.
- Appreciation for the providers from the previous meeting who really shined a light on how complex and pressure laden the situation is when dealing with youth who run.
- The point was made that it's not realistic to stop all runaways – it's about reducing, intervening, and wanting to be clear about that.
- From a law enforcement standpoint, it feels like there is a lot of red tape (this struck the interest of members). Perception from law enforcement has been that they are taking on somebody else's role or business. Kids can just walk out of the facility. Law Enforcement's perception is that because Peaks (residential facility) has limited staff, they're not always part of that pursuit. Feeling of law enforcement regarding potential liability depending on response – feeling of "damned if we do, damned if we don't." Also then dealing with mixed community response who thinks they're doing too much or not enough.
- Peaks offered perspective: Recognize perceptions run deep. Similar frustrations exist among staff and they also hear frustrations from the community.
- Echoes of complications and tensions between providers & law enforcement, desire to see more of that explored.
- The task force also requests additional discussion about trauma-informed care which CDHS does require per federal requirements for it to be provided in facilities.
- This task force is filled with a wide range of experiences: this task force needs to receive education about what people can or can't do around this

issue of running away. Lots of misconceptions, need to understand what can happen so we can recommend what can change.		
8:45 am-9:30 am	*Task Force Operations & Role*	Stephanie Villafuerte, Jordan Steffen, Keystone

- Selection of Vice Chair
  - Stephanie outlined the necessity of naming a vice chair and the role they would play (1-2 hours a month). Asked for someone to volunteer for this role, invitation to follow-up via email if interested.
- Role of Task Force
  - The mandate is to provide two different reports, the first at the end of year one and the second at the end of year two. Stephanie outlines that these are recommendations, the task force does not issue mandates.
  - This task force is deliberately diverse and everyone's opinion is important. The task force will proceed with recommendations as they see fit, but all perspectives will be included.
- Question & Answer / Discussion
  - Question posed by Kevin (TF member): Can the task force add something to what we're analyzing if it comes up? Stephanie answered that as chair, she feels that's appropriate as long as the task force is analyzing what it's been tasked to do

9:30 am-9:50 am	*The Work & Charges of the Task Force* • *Required Work & Issues* • *Reports, Process & Timelines* • *Q&A with CPO*	Keystone

The task force reviewed the Colorado General Assembly's charges outlined in House Bill 22-1375 along with the specific issues the group is tasked with analyzing, including: the sufficiency of statewide data, root causes of why youth

<table>
<tr><td colspan="3">run away from out-of-home placements, the effectiveness of current state laws and regulations, and best practices for preventing and addressing runaway behaviors.</td></tr>
<tr><td>9:50-10:00am</td><td>Break</td><td></td></tr>
<tr><td>10:00 am-
10:45 am</td><td>Our work: What we need to know to fulfill our charge</td><td>Keystone, Stephanie Villafuerte</td></tr>
<tr><td colspan="3">From the Task Force on what they need moving forward (in addition to the review of the survey details):

Request to analyze some case studies to look at what went on in specific instances.
Unsure if they understand the true scope of the problem, what youth are involved in that, what happens to them and where do they end up?
What are the conditions in different settings? We need a good look at disaggregated data.
When youth run, are there additional agencies available to get involved, what are the run periods, what is the length of stay after a run, what do incidents reports look like afterwards?
What is the data over time? Is it increasing? Is how the law is interpreted and administered shifting? We don’t know what we don’t know.
Need to hear the good and the bad of this issue.
What is the info on the number of moves or different facilities for youth and how is that provided and with whom?
We’re talking a lot about kids’ intentions but maybe they’re impulsive and it was simply a trigger vs plan. Does training account for that?
Would like to hear from facilities about how they respond, what limits they have on who they’ll accept (e.g. not accepting those who have previously run).
</td></tr>
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- Understanding the cost – non-financial – of intervention e.g. what would happen if providers started detaining youth & how that would affect them.
- From law enforcement perspective: Learn more about what community– parents, facilities – believe is the best role & protocols for law enforcement responding
- More education for law enforcement officers on how better/best to respond – for the youth and the staff perspective & what are the various routes and their implications in how youth are handled.
- Policies/procedures for law enforcement and facilities on how youth can be responded to and if authority varies based on individual.
- Need to understand how to not get to the point where kids' behavior requires a physical response. Is what treatment facilities expect the same as what is needed e.g. is giving them space actually a better option – asking kids what would have been helpful?
- If a facility can or cannot put hands on a youth, how does that impact juvenile behavior?

10:45am	Public Comment	

Steve Fisher: His interest is because of his location across the street from Tennyson Center since 1995 and has witnessed hundreds of runs and rescues. Request to look into misinformation around safety, identified a large gap in the safety net as staff at facilities can't restrain youth, and then law enforcement returns them. A fence around a property is not restraint and is not lockdown, though it is often conflated as such. He'd like a review of this with the consideration of keeping kids safe.

10:55am	Next Steps and Closing	Stephanie Villafuerte, Keystone

Stephanie thanked the task force for their time and named that this is their task force and the desire to create agendas that are responsive to the group's needs. The next meeting is January 2023.

Meeting 2 – Nov. 2, 2022

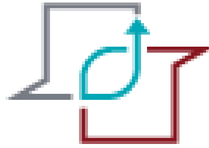
Agenda

Timothy Montoya Task Force I Kick-Off Meeting
November 2, 2022, 8am-11am
Virtual - Zoom
Facilitator: Keystone Policy Center (Berrick Abramson , Christine Scanlan)

Time	Agenda Topic	Faci itator / Presenter
8:00am	Opening & Welcome	Stephanie Villafuerte, Keystone
8:10 – 8:45	September Meeting Reflections *What were your biggest take-aways or "a-ha" moments and how is it informing how you come to this task force's work?*	Keystone
8:45 – 9:30	Task Force Operations & Role ● Select Vice Chair ● Role of Task Force ● Operating, decision making protocols ● Question & Answer / Discussion	Stephanie Villafuerte, Jordan Steffen, Keystone
9:30 – 9:50	The Work & Charges of the Task Force ● Required Work & Issues ● Reports, Process & Timelines ● Q&A with CPO	Keystone with support of Stephanie Villafuerte, Jordan Steffen
9:50 - 10:00	Break	
10:00 – 10:45	Our Work: What we need to know to fulfill our charge	Keystone with support of Stephanie Villafuerte
10:45	Public Comment	
10:55am	Next Steps & Closing	Stephanie Villafuerte, Keystone Policy Center

Meeting 2 – Nov. 2, 2022

Minutes



POLICY COLLABORATIVE
FOR CHILDREN
& FAMILIES

Meeting Minutes - Timothy Montoya Task Force

November 2, 2022 | 8am-11am

Recording

Facilitators: Keystone Policy Center

<table>
<tr><th>Time</th><th>Agenda Topic and Notes</th><th>Facilitator/Presenter</th></tr>
<tr><td>8:00 am</td><td>Opening & Welcome
Berrick Abramson from Keystone encouraged participation with the survey sent out to task force members</td><td>Stephanie Villafuerte</td></tr>
<tr><td>8:10-8:45 am</td><td>September Meeting Reflections
What were your biggest takeaways or “a-ha” moments and how is it informing how you come to this task force’s work?</td><td>Keystone</td></tr>
<tr><td colspan="3">From Task Force:
Hearing a lot about experiences from youth but not much about their accessing or awareness of services both for themselves and their families.
Appreciation for Beth Montoya’s willingness to share her story and how that should inspire everyone. Listening to the providers regarding policy/rule/statute that gets in the way of intervening with kids running away. The task force needs to understand if there are opportunities for change or recommendations to make.
Appreciation for the diversity of the youth & their experiences.</td></tr>
</table>

- Services were only available after commitment which came with lifetime consequences despite her asking/wanting services. Not being heard led to bad actions. We need a deeper understanding of what's available and the process to access
- Concern shared about overall terminology and particularly the word "runaway" feels loaded. The word is used because it's included in the language of laws written, task force member suggested maybe exploring the language piece.
- Appreciation for the providers from the previous meeting who really shined a light on how complex and pressure laden the situation is when dealing with youth who run.
- The point was made that it's not realistic to stop all runaways – it's about reducing, intervening, and wanting to be clear about that.
- From a law enforcement standpoint, it feels like there is a lot of red tape (this struck the interest of members). Perception from law enforcement has been that they are taking on somebody else's role or business. Kids can just walk out of the facility. Law Enforcement's perception is that because Peaks (residential facility) has limited staff, they're not always part of that pursuit. Feeling of law enforcement regarding potential liability depending on response – feeling of "damned if we do, damned if we don't." Also then dealing with mixed community response who thinks they're doing too much or not enough.
- Peaks offered perspective: Recognize perceptions run deep. Similar frustrations exist among staff and they also hear frustrations from the community.
- Echoes of complications and tensions between providers & law enforcement, desire to see more of that explored.
- The task force also requests additional discussion about trauma-informed care which CDHS does require per federal requirements for it to be provided in facilities.
- This task force is filled with a wide range of experiences: this task force needs to receive education about what people can or can't do around this

<table>
<tr><td colspan="3">issue of running away. Lots of misconceptions, need to understand what can happen so we can recommend what can change.</td></tr>
<tr><td>8:45 am-9:30 am</td><td>Task Force Operations & Role</td><td>Stephanie Villafuerte, Jordan Steffen, Keystone</td></tr>
<tr><td colspan="3">

Selection of Vice Chair
Stephanie outlined the necessity of naming a vice chair and the role they would play (1-2 hours a month). Asked for someone to volunteer for this role, invitation to follow-up via email if interested.
Role of Task Force
The mandate is to provide two different reports, the first at the end of year one and the second at the end of year two. Stephanie outlines that these are recommendations, the task force does not issue mandates.
This task force is deliberately diverse and everyone’s opinion is important. The task force will proceed with recommendations as they see fit, but all perspectives will be included.
Question & Answer / Discussion
Question posed by Kevin (TF member): Can the task force add something to what we’re analyzing if it comes up? Stephanie answered that as chair, she feels that’s appropriate as long as the task force is analyzing what it’s been tasked to do

</td></tr>
<tr><td>9:30 am-9:50 am</td><td>The Work & Charges of the Task Force
Required Work & Issues
Reports, Process & Timelines
Q&A with CPO</td><td>Keystone</td></tr>
<tr><td colspan="3">The task force reviewed the Colorado General Assembly’s charges outlined in House Bill 22-1375 along with the specific issues the group is tasked with analyzing, including: the sufficiency of statewide data, root causes of why youth</td></tr>
</table>

<table>
<tr><td colspan="3">run away from out-of-home placements, the effectiveness of current state laws and regulations, and best practices for preventing and addressing runaway behaviors.</td></tr>
<tr><td>9:50-10:00am</td><td>Break</td><td></td></tr>
<tr><td>10:00 am-
10:45 am</td><td>Our work: What we need to know to fulfill our charge</td><td>Keystone, Stephanie Villafuerte</td></tr>
<tr><td colspan="3">From the Task Force on what they need moving forward (in addition to the review of the survey details):
● Request to analyze some case studies to look at what went on in specific instances.
● Unsure if they understand the true scope of the problem, what youth are involved in that, what happens to them and where do they end up?
● What are the conditions in different settings? We need a good look at disaggregated data.
● When youth run, are there additional agencies available to get involved, what are the run periods, what is the length of stay after a run, what do incidents reports look like afterwards?
● What is the data over time? Is it increasing? Is how the law is interpreted and administered shifting? We don’t know what we don’t know.
● Need to hear the good and the bad of this issue.
● What is the info on the number of moves or different facilities for youth and how is that provided and with whom?
● We’re talking a lot about kids’ intentions but maybe they’re impulsive and it was simply a trigger vs plan. Does training account for that?
● Would like to hear from facilities about how they respond, what limits they have on who they’ll accept (e.g. not accepting those who have previously run).</td></tr>
</table>

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<tr><td colspan="3">

- Understanding the cost – non-financial – of intervention e.g. what would happen if providers started detaining youth & how that would affect them.
- From law enforcement perspective: Learn more about what community– parents, facilities – believe is the best role & protocols for law enforcement responding
- More education for law enforcement officers on how better/best to respond – for the youth and the staff perspective & what are the various routes and their implications in how youth are handled.
- Policies/procedures for law enforcement and facilities on how youth can be responded to and if authority varies based on individual.
- Need to understand how to not get to the point where kids' behavior requires a physical response. Is what treatment facilities expect the same as what is needed e.g. is giving them space actually a better option – asking kids what would have been helpful?
- If a facility can or cannot put hands on a youth, how does that impact juvenile behavior?

</td></tr>
<tr><td>10:45am</td><td>Public Comment</td><td></td></tr>
<tr><td colspan="3">Steve Fisher: His interest is because of his location across the street from Tennyson Center since 1995 and has witnessed hundreds of runs and rescues. Request to look into misinformation around safety, identified a large gap in the safety net as staff at facilities can't restrain youth, and then law enforcement returns them. A fence around a property is not restraint and is not lockdown, though it is often conflated as such. He'd like a review of this with the consideration of keeping kids safe.</td></tr>
<tr><td>10:55am</td><td>Next Steps and Closing</td><td>Stephanie Villafuerte, Keystone</td></tr>
<tr><td colspan="3">Stephanie thanked the task force for their time and named that this is their task force and the desire to create agendas that are responsive to the group's needs. The next meeting is January 2023.</td></tr>
</table>

Meeting 3 – Jan. 4, 2022

Agenda

Timothy Montoya Task Force Meeting Agenda

January 4, 2023 | 8am-11am

Virtual - Zoom

Facilitators: Keystone Policy Center

Trace Faust | Berrick Abramson | Cally King

Time	Agenda Topic	Facilitator / Presenter
8:00 am	• Announcing selection of Co-Chair • Task Force Member outreach	Stephanie Villafuerte
8:05 am	• Legislative Charge • Task Force Syllabus	Jennifer Superka
8:20 am	System operations and processes 1. What happens when a child runs away? 2. What happens while a child is missing from care? 3. What happens upon their return?	Jennifer Superka Keystone facilitators
9:25 am	Stretch Break	Full Group
9:30 am	An updated examination of the predictors of running away from foster care in the United States and trends over ten years (2010–2019)	Dr. Tara Richards and Caralin Branscum, PhD student, School of Criminology and Criminal Justice, University of Nebraska Omaha
10:30 am	• Wrap-up • Next Steps	Keystone facilitators
10:45 am	Public Comment	
11:00 am	Closing	Keystone Facilitators

Meeting 3 – Jan. 4, 2023

Materials

Predictors of Running from Foster Care

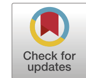
University of Nebraska Omaha

Child Abuse & Neglect 129 (2022) 105689

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg



An updated examination of the predictors of running away from foster care in the United States and trends over ten years (2010–2019)

Caralin Branscum, M.S. *, Tara N. Richards, Ph.D.

School of Criminology and Criminal Justice, University of Nebraska at Omaha, USA.

A R T I C L E I N F O

Keywords:
Child welfare
Foster care system
Foster children
Running away

A B S T R A C T

Background: Among the more than 400,000 children in foster care, there is a small group who will run away from care and face increased risks of negative outcomes. Previous studies on the predictors of running away from care use limited samples or outdated data.
Objective: The present study replicates and extends prior research by presenting an updated analysis of predictors of running away from foster care as well as 10-year trends in the prevalence and predictors of running from care.
Participants and setting: This study uses the Adoption and Foster Care Analysis and Reporting System (AFCARS) data to assess the runaway status of 597,911 children who were involved in foster care in 2019. Longitudinal trend analyses utilize AFCARS data from 2010 to 2019.
Method: Using chi-square/*t*-tests and binary logistic regression analyses, this study investigates individual- and case-level predictors of running away from foster care programs.
Results: Findings show that girls (OR = 1.29, $p < .001$), African American children (OR = 1.89, $p < .001$), and older children (OR = 1.61, p < .001) are at increased risk of running away from foster care. Removal reasons such as child substance abuse (OR = 1.65, $p < .001$), abandonment (OR = 1.38, p < .001), and child behavioral problems (OR = 1.31, p < .001) are also associated with an increased risk. Analysis of 10-year trends shows a steady decline in running from care: 1.40% in 2010 to 0.98% in 2019. The profile of risk factors is stable overall, with a few notable exceptions.
Conclusions: The percent of children running from foster care is at a 10-year low. Prevention and intervention efforts regarding running from care must focus on the needs of African American and Hispanic children, especially girls, as well as children with substance use or behavior problems. Given that programs rarely have prospective information regarding why children leave care and the negative consequences of labeling children as “runaways,” shifting language to “missing from care” should be considered.

1. Introduction

There are more than 400,000 children in foster care programs in the United States (U.S.) at any given time (U.S. Department of Health and Human Services, 2018). Children may be placed in foster care because of abuse or neglect in their family of origin, parental

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https://doi.org/10.1016/j.chiabu.2022.105689
Received 24 January 2022; Received in revised form 19 April 2022; Accepted 24 May 2022
Available online 6 June 2022
0145-2134/Published by Elsevier Ltd.

abandonment, death, or incarceration, among other reasons (U.S. Department of Health and Human Services, 2018). Among children in foster care, some may run away or otherwise go missing from their foster care placements, thereby increasing their risk of victimization and a host of other negative outcomes (e.g., substance use, dropping out of school; Courtney & Zinn, 2009; Crosland & Dunlap, 2015; Latzman et al., 2019).

Given the risks of running from foster care placement, prior research has focused on the individual- and case-level factors that predict running from care; however, most studies rely on data from single states/jurisdictions or specific care settings, (e.g., Courtney et al., 2005; Crosland & Dunlap, 2015; Nesmith, 2006). The one previous study that utilize national data – the National Adoption and Foster Care Analysis and Reporting System (AFCARS) – relied on a single year of data, from 2009, and has become quite dated (Lin, 2012).

The present study aims to replicate and extend prior research by using AFCARS data to present (1) a multivariate analysis of predictors of running from care using the most recent data (2019) as well as (2) trends in predictors from 2010 to 2019. Findings show that running behavior dramatically decreased over the 10-year study period, and that most predictors of running remained stable. Findings are discussed in the context of prevention and intervention strategies for addressing running behavior among children in foster care as well as priorities for future research and practice.

1.1. Running behavior in foster care programs

Children involved in foster care are about twice as likely to run away than children in the general population (Sedlak et al., 2005), and while many children who run from care return after approximately one week, roughly a quarter are missing from care for five or more weeks (Courtney et al., 2005). Running from a foster care placement is associated with an increased risk of many harmful behaviors. For example, children who have run away from care report higher rates of substance abuse (Courtney & Zinn, 2009), crime perpetration (Crosland & Dunlap, 2015; Yoder et al., 2003), truancy from school, and dropping out of school (Crosland & Dunlap, 2015; Sullivan & Knutson, 2000), compared to children who have not run from their foster care placement. Running from foster care has also been associated with an increased risk of sexual exploitation and trafficking (Cohen et al., 1991; Latzman et al., 2019; Yates et al., 1988), repeated victimization (Hoyt et al., 1999; Yates et al., 1988), exposure to STDs/STIs (Booth et al., 1999; Courtney et al., 2005), and attempted suicide (Yates et al., 1988).

Given that children who run from care are particularly vulnerable to violence and victimization, understanding the predictors of running from care is paramount. Prior research has included qualitative case studies (e.g., Clark et al., 2008) or interviews with children who have run from their foster care placements (e.g., Courtney et al., 2005). In addition, quantitative research has predominantly analyzed administrative data from single state child welfare systems (e.g., Illinois, Courtney et al., 2005) or specific care settings (e.g., family foster care, Nesmith, 2006; specialized foster care, Fasulo et al., 2002).

Taken together, these prior studies identify a host of individual- and case-level predictors of running from foster care. For example, research shows that girls (Fasulo et al., 2002; Sunseri, 2003) and children of color (African American or Hispanic children; Dworsky et al., 2018; Wulczyn, 2020; America Indian/Alaska Native children; Nesmith, 2006) are at an increased risk for running away from care. Additionally, running behavior peaks around 16 to 18 years of age (Courtney et al., 2005; Sunseri, 2003). Other individual-level risk factors include substance abuse (Courtney et al., 2005; Courtney & Zinn, 2009; Eisengart et al., 2008; McIntosh et al., 2010), previous running behavior (Bowden & Lambie, 2015; Courtney & Zinn, 2009; Sunseri, 2003), mental and physical disabilities (Clark et al., 2008; Courtney et al., 2005; Courtney & Zinn, 2009), and sexual minority/LGBTQ+ identity (Fish et al., 2019; Wilson & Kastanis, 2015).

In addition to individual characteristics, there are several placement-level factors associated with running from care. Using a sample of over 14,000 children in Illinois who had run away from care and returned, Courtney et al. (2005) found that children who were not placed with their siblings were more likely to run from placement than children who were placed with their siblings. Similarly, children ran away more often when placed in group homes—instead of foster families—and with foster families who are not relatives, compared to placement with foster families who are relatives (Courtney et al., 2005). Furthermore, placement history and instability are strongly associated with running behavior. For instance, children are more likely to run away from care when they experience greater numbers of removals from their family of origin and more changes in their foster care placements (Bowden & Lambie, 2015; Courtney & Zinn, 2009; English & English, 1999; Zimmerman et al., 1997).

In addition to the aforementioned research, one study to date has examined the population of children in foster care using the Adoption and Foster Care Analysis and Reporting System (AFCARS) data from 2009 (Lin, 2012). Lin's analysis substantiated the general demographic profile of children who are at greatest risk for running away – females, children of color, and older youth. She also found that children who are removed from their family of origin at an older age are more likely to run than those who are younger at first removal and that physical and mental health diagnoses are correlated with a higher risk of running away (Lin, 2012).

1.2. Theoretical explanations for running behavior

Broadly, the literature suggests that children run away from home as a coping behavior (Cochran et al., 2002; Courtney et al., 2005; Crosland & Dunlap, 2015; Safyer et al., 2004). Running behavior predecessors include perceived or actual family hostility towards or rejection of the child (e.g., as in the case of a child who identifies as LGBTQ+), caregiver or interfamilial conflict, depressive symptomatology, and abuse (Cochran et al., 2002; Safyer et al., 2004; Thrane et al., 2006). Taken together, Hammer et al. (2002) summarize the nature of why children run away by noting that, “children may leave to protect themselves or because they are no longer wanted in the home” (p. 2).

Crossland et al. (2018) have specifically reasoned children run away from foster care due to broad categories of *running to* and *running from* behaviors. To elaborate, *running to* behaviors were categorized as seeking out friends, family, and a sense of normalcy (e.g., parties, sporting events, and extracurricular activities) (see also Courtney et al., 2005). For instance, research has found that children are more likely to run away from care when their families of origin are comprised of a single-parent caregiver, compared to two-parent households (Lin, 2012), perhaps because the child fills a responsibility as a caretaker to their sole parent or is a caretaker to siblings. In contrast, *running from* behaviors were characterized as those aimed at avoiding negative environments such as foster care staff, families, and peers that make them feel unwanted, unloved, or prevent them from engaging in activities the child desires (e.g., dating; Crosland & Dunlap, 2015; Courtney et al., 2005; Fasulo et al., 2002). To that end, research shows that children in foster care placements report higher rates of physical and sexual abuse from their caregivers than children not living in foster care placements (Euser et al., 2014) as well as higher rates of exposure to violence (e.g., violence in their neighborhoods, violence between caregivers) (Turney & Wildeman, 2017).

2. Current study

Prior research has demonstrated that running away is concentrated among children in foster care and that children who run away from care are at an increased risk of violence and other harmful outcomes. While prior research has examined the individual and system-level predictors of running away from care, most of these prior studies have focused on single jurisdictions/states or specific care settings (e.g., Courtney et al., 2005; Crosland & Dunlap, 2015). Further analyses by Lin (2012) provided a foundation for understanding the national landscape of children who run away; however, these studies represent an analysis of a single year (2009) of annual national data and have become quite dated. To this end, the present study provides a 10-year update to Lin's (2012) analysis by replicating her research using 2019 AFCARS data and providing an analysis of trends in predictors of running from care from 2010 to 2019.

3. Methodology

3.1. Sample

Data for this study were drawn from the Adoption and Foster Care Analysis and Reporting System (AFCARS) from the National Child Abuse and Neglect Data System (NCANDS). These data contain case-level information for all children in foster care or who are adopted through states' child welfare agencies. The U.S. Department of Health and Human Services houses the annual data collection effort. Data reporting to AFCARS is mandatory for all Title IV-E agencies. Each fiscal year the AFCARS data reflects the reporting period between October 1 of the prior year and September 30 of the current year. For example, the AFCARS data for the fiscal year 2019 was collected between 10/1/2018 through 9/30/2019. This study first examined the 597,911 children in foster care in 2019; AFCARS data for years 2010 to 2019 was used for an analysis of 10-year trends.

3.2. Measures

Following previous research by Lin (2012), we included children's age, sex, and race/ethnicity as well as seven independent control variables: children's age at first removal, number of removals from the family of origin, number of placements, duration of current placement, reason for removal, clinically diagnosed disability, and original family structure. Census region was also included in the present analysis.

3.2.1. Dependent variable

The child's *runaway status* was derived from the AFCARS variable for the child's current placement in foster care. The AFCARS report defined a child's placement as one of the following: (1) pre-adoptive home, (2) foster family home, relative, (3) foster family home, non-relative, (4) group home, (5) institution, (6) supervised independent living, (7) trial home visit, and (8) runaway. The only placement that was excluded in this study was "supervised independent living" since the foster care youth lives independently. For this study, placement was dichotomized (0 = not runaway (includes all other placement settings), 1 = runaway).

3.2.2. Independent variables

Sex was coded dichotomously (0 = male; 1 = female). Since the AFCARS report only provides the child's birth date, the *child's age* was computed by subtracting the date of birth from the reporting year. Like Lin (2012), children were excluded if they were younger than 0 years-old (which occurred in the event of errors in the dataset) and older than 23 years-old. Lin explains the decision to include individuals between 18 and 23 years-old was made because some states (e.g., Massachusetts and Connecticut) have extended foster care services to age 23 (Child Welfare League of America, 2009). *Race/ethnicity* was coded as five mutually exclusive categories (1 = White, non-Hispanic, 2 = African American, non-Hispanic, 3 = American Indian/Alaskan Native, non-Hispanic, 4 = Asian, 5 = Other, non-Hispanic (including Hawaiian/Other Pacific Islander, and more than one race, and 5 = Hispanic)). We replicated Lin's (2012) derived measure for the *age at first removal* from the caretaker of origin. This measure was created by subtracting the child's birth year by the first removal year. Children who were younger than 0 years-old (because of a coding error) and older than 17 years-old at time of first removal were omitted from the sample.

We also replicated Lin's (2012) three indicators for placement instability. First, we measure the *duration* in months a child had been

in their most recent foster care episode. To do this, we take the number of days between the date of placement in the most recent foster care setting and the end of the fiscal year and divide by 30.417. Second, the remaining two indicators were pulled directly from the AFCARS report. The first of these indicators consists of the *number of placement* settings in the current foster care episode. This includes the child's current placement. The second indicator consists of the *total number of removals* from the child's home of origin over the child's entire life, including the current removal.

Reason for removal from original family is comprised of 13 circumstances that are dichotomously coded (0 = no, 1 = yes) and include: (1) physical abuse, (2) sexual abuse, (3) neglect, (4) parent substance use (drugs or alcohol), (5) child substance use (drugs or alcohol), (6) child disability, (7) child behavior problem, (8) parent death, (9) parent incarceration, (10) caretaker inability to cope, (11) abandonment, (12) relinquishment, and (13) inadequate housing. *Clinically diagnosed disability* was collected in the AFCARS report through several variables. First, a series of five dichotomous variables indicated that a child had been clinically diagnosed with any of the following disabilities: intellectual disability,[1] visual or hearing impairment, physical disability, emotionally disturbed, and other condition that requires special care (e.g., asthma, AIDS, autistic spectrum disorder). Additionally, the AFCARS reported whether a child had been diagnosed with *any* disability in which "yes" referred to the children who had responded "yes" to any of the previous dichotomous variables. In this variable, children who responded with "no" and "not yet to be determined" were collapsed into a single category. This was done because "no" indicated that a child had undergone clinical testing and had been found to have no disability, whereas "not yet to be determined" indicated that a child had not been assessed by a professional. In this study, clinically diagnosed disability was operationalized categorically (0 = no disability/not yet determined (reference group), 1 = intellectual disability, 2 = visual or hearing impaired, 3 = physical disability, 4 = emotionally disturbed, 5 = other disability). The AFCARS data reports *original family structure* using five categories (1 = married couple, 2 = unmarried couple, 3 = single female family (reference group), 4 = single male family, 5 = undetermined families). Lastly, we also added the U.S. *census region* where the child was located. We used the U.S. Census Bureau's official regions (1 = Northeast, 2 = Midwest, 3 = South (reference group), 4 = West).

3.3. Analytical strategy

We begin by presenting an analysis of the 2019 AFCARs data. Descriptive statistics were calculated for all study variables and a series of bivariate analyses were conducted to assess significant differences between children who did and did not run away (Table 1). Independent samples *t*-tests were used to assess all continuous variables, and chi-square analyses were used to assess all categorical variables. Then, a binary logistic regression model was estimated to evaluate the independent effects of all study variables on runaway status (see Table 2). The results of the binary logistic regression are presented as an odds ratio. Odds ratios can be interpreted as the relative odds of an outcome (here, runaway status) dependent on an independent variable (e.g., a child's age, race, disability status). Finally, we replicated our binary regression model using AFCARS data for 2010 to 2018 to examine trends in the prevalence and predictors of runaway behavior over the ten years since Lin's (2012) study (i.e., 2010 to 2019; see Tables 3 and 4). Regarding missing data, approximately 9.16% of data for the independent variables were missing from the AFCARS files. Specifically, 21 variables had <1% missing data; 2 variables had 1–3% missing data; and 1 variable had 3.65% missing data. We also assessed for cell missingness and found that cell missing was 0.61%. Alpha was set at $p < .05$ for all analyses.

4. Results

Descriptive statistics for youth in foster care in 2019 as well as bivariate comparisons for children who did and did not run away from foster care are presented in Table 1. Regarding runaway status, findings showed that running away from foster care is a rare event: less than 1% (0.98%) of children's foster care placement was listed as "runaway". Children in foster care ranged from 0 to 23 years old (*M* = 8.27; *SD* = 5.56). Children who ran away from foster care were significantly older (*M* = 16.87; *SD* = 1.88) than children who did not run away (*M* = 8.18; *SD* = 5.52, *t* = −120.53, *df* = 597,909, $p < .001$). Girls comprised slightly less than half of children in foster care (48.31%); however, were significantly more likely to runaway (54.97%) ($x^2 = 105.29$, *df*(1), $p < .001$).

There were statistically significant racial differences between children who ran away from foster care and children who did not. Despite White children making up 46.58% of the foster care population, they only comprised 30.94% of children who ran away from foster care ($x^2 = 760.51$, *df*(5), $p < .001$). In contrast, African American children comprised the highest proportion of children who ran away from care (33.22%), despite only consisting of about 22% of the foster care population. In addition, Hispanic children were also disproportionately represented as having run away (26.37%) ($p < .001$). The age a child was first removed from their family of origin ranged from 0 to 18 years old (*M* = 5.79, *SD* = 5.13). Children who ran away from foster care were more likely to be older when removed from their family of origin (*M* = 12.01, *SD* = 4.90), compared to children who did not run away (*M* = 5.73, *SD* = 5.09), *t* = −94.06, *df* = 597,909, $p < .001$.

All three indicators of placement instability were significantly different for children who did and did not run away from foster care. First, children in care had been removed on average 1.24 times (*SD* = 0.57, *Range* = 1–18); however, children who had runaway had been removed an average of 1.58 times (*M* = 1.58, *SD* = 0.89) compared to children who did not run away (*M* = 1.24, *SD* = 0.56), *t* = −45.67, *df* = 597,909, $p < .001$. Second, while children had an overall average of 2.78 prior foster care placements (*SD* = 3.36, *Range*

[1] AFCARS continues to use the term "mental retardation", however, the term intellectual disability is now the preferred term by the federal government and has been codified in the Federal Register for the evaluation of mental impairments in children and adults (see Social Security Administration, 2013).

Table 1
Descriptive statistics for children in foster care and bivariate differences based on runaway status ($N = 597,911$).

Variable	M (SD)/%	M (SD)/%		%/M^Diff
	Total sample N = 597,911	Runaway n = 5867	Non-runaway n = 592,044	
Female	48.31%	54.97%	48.24%	6.73%***
Race/ethnicity				
White	46.58%	30.94%	46.74%	−15.80%***
Black/African American	22.00%	33.22%	21.89%	11.33%***
American Indian/Alaskan Native	2.31%	1.98%	2.31%	−0.33%***
Asian	0.50%	0.55%	0.50%	0.04%***
Other	8.05%	6.95%	8.06%	−1.11%***
Hispanic	20.56%	26.37%	20.50%	5.87%***
Clinically diagnosed disability				
No disability	74.36%	58.96%	74.51%	−15.55%***
Intellectual disability	0.52%	0.14%	0.53%	−0.39%***
Visually or hearing impaired	0.79%	1.43%	0.78%	0.65%***
Physical disability	0.27%	0.09%	0.27%	−0.19%***
Emotionally disturbed	10.68%	24.29%	10.55%	13.74%***
Other disability	13.38%	15.10%	13.37%	1.74%***
Original family structure				
Single female	47.77%	52.51%	47.72%	4.79%***
Married couple	18.02%	18.82%	18.02%	0.80%***
Unmarried couple	24.74%	13.04%	24.85%	−11.82%***
Single male	5.55%	10.53%	5.50%	5.03%***
Unknown	3.92%	5.10%	3.91%	1.19%***
Removal reason				
Physical abuse	12.92%	11.32%	12.93%	−1.62%***
Sexual abuse	4.05%	6.05%	4.03%	2.02%***
Neglect	65.65%	51.68%	65.78%	−14.11%***
Parent substance abuse	40.41%	16.33%	40.65%	−24.32%***
Child substance abuse	2.32%	6.58%	2.28%	4.30%***
Child disability	1.92%	2.68%	1.91%	0.76%***
Child behavior problem	7.61%	34.55%	7.35%	27.20%***
Parent death	0.85%	1.38%	0.85%	0.53%***
Parent incarceration	7.55%	4.40%	7.58%	−3.18%***
Caretaker inability to cope	14.37%	18.19%	14.33%	3.85%***
Abandonment	4.96%	12.00%	4.89%	7.11%***
Relinquishment	0.99%	2.10%	0.98%	1.12%***
Inadequate housing	11.76%	7.65%	11.80%	−4.15%***
Census region				
South	37.27%	28.45%	37.36%	−8.91%***
Northeast	11.93%	15.20%	11.90%	3.31%***
Midwest	26.89%	25.94%	26.90%	−0.96%***
West	23.90%	30.41%	23.84%	6.57%***
Age	8.27 (5.56) Range = 0–23	16.87 (1.88) Range = 0–22	8.18 (5.52) Range = 0–23	8.69***
Age at first removal	5.79 (5.13) Range = 0–18	12.01 (4.90) Range = 0–17.99	5.73 (5.09) Range = 0–18	6.28***
Duration (months)	9.44 (11.64) Range = 0–252	5.00 (6.83) Range = 0–116	9.49 (11.67) Range = 0–252	−4.49***
Number of previous placements	2.78 (3.36) Range = 1–97	6.67 (7.60) Range = 1–89	2.75 (3.27) 1–98	3.92***
Number of total removals	1.24 (0.57) Range = 1–17	1.58 (0.89) Range = 1–8	1.24 (0.56) 1–18	0.34***

* p < .05, ** p < .01, *** p < .001.

= 1–99), children who ran away had four additional prior placements ($M = 6.67$, $SD = 7.60$) compared to children who did not run away ($M = 2.75$, $SD = 3.30$, $t = -89.38$, $df = 597,909$, $p < .001$). Third, children who had runaway had spent approximately four months less time in their current placement ($M = 5$, $SD = 6.83$) than children who did not run away ($M = 9.49$, $SD = 11.67$), $t = 29.38$, $df = 597,909$, $p < .001$.

Regarding reason for removal, most children in foster care were removed from their primary caregivers for reasons of neglect (65.65%) or parental substance abuse (40.41%), while 7.61% were removed for the child's own behavioral problems. In comparison, 34.55% of children who had run away from foster care were removed from their family of origin for behavioral problems, compared to children who did not runaway (7.35%) ($x^2 = 6111.28$, $df(1)$, $p < .001$). In contrast, children who experienced neglect were under-represented in the runaway group compared to the non-runaway group, 51.68% and 65.78%, respectively ($x^2 = 512.57$, $df(1)$, $p < .001$). Moreover, caretaker inability to cope was significantly related to runaway status, (18.19% versus 14.33%, $x^2 = 70.08$, $df(1)$, $p < .001$) as was children's disability status (2.68% versus 1.91%, $x^2 = 18.05$, $df(1)$, $p < .001$), child substance abuse problems (6.58%

Table 2
Binary logistic regression model examining predictors of runaway status among children in foster care (N = 597,911).

Variable	B	SE	95% CIs		OR
Female	0.25	0.03	1.22	1.36	1.29***
Race/ethnicity					
Black/African American	0.64	0.04	1.77	2.03	1.89***
American Indian/Alaskan Native	0.37	0.10	1.19	1.76	1.45***
Asian	0.21	0.18	0.86	1.77	1.23
Other	0.43	0.06	1.37	1.71	1.53***
Hispanic	0.60	0.04	1.69	1.96	1.82***
Clinically diagnosed disability					
Intellectual disability	−0.78	0.36	0.23	0.93	0.46
Visually or hearing impaired	0.23	0.12	1.00	1.58	1.26
Physical disability	−0.54	0.46	0.24	1.43	0.58
Emotionally disturbed	0.05	0.03	0.98	1.12	1.05
Other disability	−0.16	0.04	0.79	0.92	0.85***
Original family structure					
Married couple	−0.21	0.04	0.76	0.88	0.81***
Unmarried couple	−0.02	0.04	0.90	1.06	0.98
Single male	0.13	0.05	1.03	1.25	1.14**
Unknown	−0.04	0.06	0.85	1.09	0.96
Removal reason					
Physical abuse	−0.03	0.04	0.89	1.06	0.97
Sexual abuse	−0.10	0.06	0.81	1.01	0.90
Neglect	0.16	0.03	1.10	1.24	1.17***
Parent substance abuse	−0.10	0.04	0.84	0.98	0.91*
Child substance abuse	0.50	0.06	1.47	1.85	1.65***
Child disability	−0.35	0.09	0.60	0.84	0.71***
Child behavior problem	0.27	0.03	1.22	1.40	1.31***
Parent death	−0.01	0.12	0.79	1.24	0.99
Parent incarceration	−0.07	0.07	0.82	1.06	0.93
Caretaker inability to cope	0.05	0.04	0.98	1.13	1.05
Abandonment	0.32	0.04	1.27	1.51	1.38***
Relinquishment	0.06	0.10	0.88	1.29	1.06
Inadequate housing	0.05	0.05	0.95	1.17	1.06
Census region					
Northeast	0.27	0.05	1.20	1.43	1.31***
Midwest	0.26	0.04	1.20	1.39	1.30***
West	0.61	0.04	1.70	1.98	1.84***
Age	0.48	0.01	1.59	1.63	1.61***
Age at first removal	0.01	0.00	1.00	1.02	1.01**
Duration (months)	−0.06	0.00	0.94	0.94	0.94***
Number of previous placements	0.03	0.00	1.03	1.04	1.03***
Number of total removals	0.12	0.02	1.09	1.18	1.13***
Intercept	−12.11	0.12	–	–	–
F (DF)	20,141.24 (36)***				
Nagelkerke R square	0.32				

Note: Reference Categories: White, No disability, Single female, and South.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

Table 3
Ten year trends for the prevalence of children running away from FC programs (2010–2019).

Year	Children in foster care programs *N*	Children who ran away *N*	Prevalence of children who ran away %
2010	534,056	7456	1.40%
2011	535,944	7340	1.37%
2012	526,366	6235	1.18%
2013	542,315	6121	1.13%
2014	569,333	6344	1.11%
2015	592,639	6537	1.10%
2016	594,285	6470	1.09%
2017	610,723	6707	1.10%
2018	608,826	6162	1.01%
2019	597,911	5867	0.98%
10-Year average	571,239.80	6523.90	1.14%

Table 4

Ten year trends for the predictors of children running away from FC programs (2010–2019).

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	10-Year average
Married couple	1.02	1.00	0.96	0.98	1.00	1.08	0.99	1.04	1.08	0.81	0.99
Unmarried couple	0.72	0.72	0.71	0.77	0.75	0.82	0.75	0.76	0.87	0.98	0.78
Single male	1.00	0.92	0.95	1.00	1.05	1.13	1.07	1.03	1.06	1.14	1.03
Unknown	1.00	0.92	1.06	0.90	0.97	1.12	0.88	0.99	1.10	0.96	0.99
Female	1.50	1.34	1.37	1.37	1.41	1.45	1.45	1.42	1.33	1.29	1.39
Black/African American	1.54	1.55	1.55	1.46	1.53	1.62	1.55	1.56	1.77	1.89	1.60
American Indian/Alaska Native	1.21	1.88	1.92	1.61	1.57	1.36	1.56	1.76	1.51	1.45	1.58
Asian	1.44	1.64	1.56	1.34	1.33	0.90	0.94	1.06	1.01	1.23	1.24
Other	1.35	1.29	1.56	1.52	1.49	1.45	1.37	1.40	1.50	1.53	1.45
Hispanic	2.09	2.23	2.07	1.87	1.86	1.89	1.78	1.79	1.69	1.82	1.91
Intellectual disability	0.51	0.46	0.53	0.75	0.43	0.62	0.43	0.43	0.30	0.46	0.49
Visually/hearing impaired	1.15	1.26	1.52	1.76	1.44	1.02	1.12	1.18	1.08	1.26	1.28
Physical disability	0.76	0.84	0.52	0.92	0.84	0.53	0.35	0.88	0.38	0.58	0.66
Emotionally disturbed	0.95	0.99	1.17	1.27	1.14	1.06	1.09	1.12	1.15	1.05	1.10
Other disability	0.96	0.94	1.09	1.25	1.18	1.04	0.99	0.91	1.03	0.85	1.03
Northeast	0.69	0.62	0.75	0.66	0.61	0.81	0.90	0.91	0.81	1.31	0.81
Midwest	0.92	1.00	1.11	1.29	1.30	1.31	1.47	1.23	1.19	1.30	1.21
West	1.46	1.53	1.55	1.77	1.96	2.06	2.20	1.86	1.84	1.84	1.81
Age at first removal	1.01	1.01	1.01	1.02	1.02	1.01	1.02	1.02	1.01	1.01	1.01
Duration (months)	0.94	0.94	0.94	0.93	0.93	0.93	0.94	0.94	0.93	0.94	0.94
Number of previous placements	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.04	1.03	1.03	1.04
Number of total removals	1.12	1.10	1.13	1.17	1.14	1.14	1.20	1.20	1.12	1.13	1.15
Age	1.59	1.58	1.60	1.57	1.63	1.59	1.59	1.62	1.63	1.61	1.60
Physical abuse	0.94	1.04	1.04	0.95	0.95	1.00	0.95	0.92	1.04	0.97	0.98
Sexual abuse	0.97	0.99	0.98	0.86	0.96	0.95	0.89	0.85	0.85	0.90	0.92
Neglect	1.14	1.22	1.16	1.20	1.11	1.13	1.14	1.17	1.09	1.17	1.15
Parent substance abuse	1.09	1.14	1.27	1.10	1.23	1.18	0.99	0.91	0.94	0.91	1.07
Child substance abuse	1.43	1.47	1.55	1.40	1.32	1.43	1.38	1.39	1.39	1.65	1.44
Child disability	0.77	0.78	0.71	0.79	0.75	0.66	0.67	0.56	0.58	0.71	0.70
Child behavior problem	1.06	1.19	1.14	1.14	1.11	1.07	1.13	1.30	1.26	1.31	1.17
Parent death	0.99	0.99	1.15	1.06	1.23	1.07	0.85	0.84	0.86	0.99	1.00
Parent incarceration	1.00	0.94	0.93	0.97	0.86	0.83	0.96	0.88	0.99	0.93	0.93
Caretaker inability to cope	1.19	1.20	1.09	1.10	1.03	1.02	1.01	1.07	1.04	1.05	1.08
Abandonment	1.36	1.41	1.51	1.60	1.55	1.48	1.42	1.37	1.35	1.38	1.44
Relinquishment	0.88	1.07	1.05	0.89	1.07	1.07	0.98	1.00	1.06	1.06	1.01
Inadequate housing	1.14	0.99	1.12	1.17	1.10	1.01	1.02	1.11	1.07	1.06	1.08

Notes: $p < 0.05$, $p < 0.01$, $p < 0.001$ Reference Categories: White, No disability, Single female, and South

versus 2.28% $x^2 = 474.62$, *df*(1), $p < .001$), abandonment (12.00% versus 4.89%, $x^2 = 623.60$, *df*(1), $p < .001$), and sexual abuse (6.05% versus 4.03%, $x^2 = 60.97$, *df*(1), $p < .001$). In contrast to Lin's (2012) findings, these analyses also demonstrated that voluntary relinquishment of parental rights was overrepresented among children who ran away: relinquishment of parental rights was present in 2.10% of children who ran away from foster care compared to 0.98% of children who did not run away, $x^2 = 74.33$, *df*(1), $p < .001$.

Regarding clinically diagnosed disabilities, there were statistically significant differences between children who ran away from foster care and children who did not, $x^2 = 1284.03$, *df*(5), $p < .001$. However, inconsistent with Lin's (2012) analysis of 2009 AFCARS data, the present analysis using 2019 data did not find that children who had runaway were overrepresented across each type of disability. Specifically, children who had runaway had higher rates of being visually or hearing impaired (1.43% versus 0.78%), having an emotional disturbance (24.29% versus 10.55%), and having "other" disabilities (15.10% versus 13.37%), compared to children who had not runaway; however, children who had runaway were underrepresented among children with an intellectual disability (0.14% versus 0.53%) or a physical disability (0.09% versus 0.27%).

Regarding original family structure, nearly half of children in foster care had been removed from a single-female caregiver (47.77%) compared to a married couple (18.02%) or a single-male caregiver (5.55%). Original family structure was significantly related to running away from foster care, $x^2 = 644.17$, *df*(4), $p < .001$. Children who had been removed from a single male caregiver of origin (10.52%) and single female care giver of origin (4.81%) were most disproportionately overrepresented among children who had run away, while children who had been removed from an unmarried couple were most disproportionately underrepresented among children who had run away. In contrast to Lin's (2012) findings, children removed from married couples were also overrepresented—although only slightly—among children who had run away (18.82% versus 18.01% for non-runaways).

Most foster care children were in the southern census region (32.27%). Children who ran away, however, were most likely to be in the northeast (15.19% versus 11.90%) and western (30.38% versus 23.84%) census regions ($x^2 = 281.28$, *df*(3), $p < .001$).

Next, a binary logistic regression model was estimated to examine the relationship between the independent variables and runaway status. To begin, age and female sex was associated with running away. Specifically, for every year of age, the odds of running away increased by 1.61 ($p < .001$), while girls had 1.29 times greater odds of running away than boys ($p < .001$). Additionally, African American, Native American, children of "Other" races, and Hispanic children were at an increased odds of running away compared to White children with an increase in the comparative odds of 89%, 45%, 53%, and 82% respectively.

There were also significant relationships between running away and the age at first removal, number of removals, number of foster care placements, and duration spent in foster care. Specifically, for every year older a child was at the time of their first removal, there was 1.01 times greater odds of running away ($p = .008$) and each additional removal was associated with 1.13 greater odds of running away ($p < .001$). Additionally, each additional placement was associated with 1.03 greater odds of running away ($p < .001$), while each additional month a child spent in their current foster care placement was associated with a 6% decrease in the odds of running away from the placement ($p < .001$).

Regarding the relationship between removal reason and runaway status, neglect ($OR = 1.17$, $p < .001$), child substance abuse ($OR = 1.64$, $p < .001$), child behavior problems ($OR = 1.31$, $p < .001$), and abandonment ($OR = 1.38$, $p < .001$) were each associated with an increase in the odds of a child running away from placement compared to children who were not removed for those respective reasons. Comparatively, parental substance abuse was associated with a 9% decrease in the odds of running away compared to children who had not been removed for parental substance abuse ($p = .01$). Removal due to a child's disability status was associated with a 29% reduction in odds of running away ($p < .001$).

Among children with clinically diagnosed disabilities, those with an 'intellectual disability' were associated with a 54% reduction in the odds of running away ($p = .03$) while having an 'other disability' was associated with a 15% decrease in the odds of running away compared to those with no disability. In addition, children who had been removed from families of origin consisting of married couples had a 19% decrease in the odds of running away ($p < .001$), compared to children whose family of origin included a single female household. Children from single male households of origin, in contrast, had 1.13 times greater odds of runaway from their foster care placement ($p = .007$). Finally, census region was related to running away with children from the Northeast, Midwest, and Western regions all associated with an increased odds of running away compared to children in foster care in the Southern census region ($p < .001$).

Lastly, we present a series of binary logistic regression analyses that chart 10-year trends for running behavior from foster care from 2010 to 2019. First, we present 10-year trends for the prevalence of running away from foster care programs (see Table 3). In 2010, about 1.40% of children in the AFCARS data were identified as having run away from foster care. Over the 10-year study period there has been a consistent decline in the percentage of children who run away from care, with 2019 data showing that 0.98% of children in the AFCARs data had run from care.

Next, we present 10-year trends in the odds ratios for individual- and case-level variables predicting running away from care (see Table 4). Findings show an overwhelmingly stable profile of predictors from 2010 to 2019; however, there are some notable exceptions. For example, in 2019 (and 2015) single male households of origin is a significant predictor of running behavior, but not in other previous years. In addition, children who identified as Asian were significantly more likely to run away from foster care in years 2010 to 2012, but not since 2012. Further, inadequate housing has been sporadically related to an increased risk for running from care; however, not since 2018.

Finally, the relationship between the different disability types and running behavior has been intermittently related to running behavior across the 10-year period. For example, although not a significant predictor of running from care in 2019, visual/hearing impairments and emotional disturbances have been identified as increasing the likelihood of running in previous years, while both intellectual disabilities and physical disabilities have been associated with a decreased likelihood. In comparison, having an 'other disability' has been previously identified as both increasing and decreasing the risk of running behavior.

5. Discussion

Prior research on running away from foster care has primarily used interviews with children who have run from care or administrative record reviews from single state/jurisdictions or specific care settings (e.g., Courtney et al., 2005; Crosland & Dunlap, 2015; Nesmith, 2006). Lin (2012) provided the first national profile on children who run away from foster care using 2009 AFCARS data. Although AFCARS data is collected annually, we know of no other study that has sought to replicate Lin's analysis with additional years of data or examine patterns over time. The present research provides a 10-year update regarding predictors of running from foster care using 2019 AFCARS data and examines trends in the prevalence and predictors of running from care from 2010 to 2019.

First, in regard to our primary aim, the analyses presented here replicated most findings from Lin (2012). Consistent with prior work (Clark et al., 2008; Fasulo et al., 2002; Lin, 2012; Sunseri, 2003), the present study found that girls were more likely to run away from care compared to boys. In addition, race was the strongest predictor of running from care with children of color at a greater risk of running away compared to White children. Specifically, we found that African American children were at the greatest risk of running away; then Hispanic children, children from "Other" races, and American Indian/Alaska Native children. In comparison, Lin's (2012) findings showed that Hispanic children had the highest risk of running away, then American Indian/Alaska Native children, children from "Other" races, and African American children. Additionally, the present results showed that Asian children were not statistically more or less likely to run compared to White children; however, Lin's (2012) previous findings showed that Asian children were nearly 54% more likely to run away than White children.

Regarding disabilities, 'other' disability diagnoses – asthma, autism spectrum disorder, and cancers – were associated with a decreased risk of running away (see also Courtney & Zinn, 2009). In contrast, Lin (2012) found that multiple disability types (e.g., visual/hearing impairments, intellectual disabilities) were associated with a reduced risk of running away compared to having no disabilities. Further, Lin's findings regarding original family structure were partially replicated. Like in Lin's analysis children who had been removed from married couples were less likely to run than those who had been removed from single female households of origin; however, diverging from Lin's findings, the present analysis showed that children who were removed from single-male households were at a greater risk of running away compared to children who had been removed from single female households.

Also consistent with Lin (2012), the present findings showed that child substance abuse was the most important removal reason when anticipating risk of running away; here, child behavior problems were also an important risk factor. Further, the present study found that children who ran away from foster care were more likely to be older (approximately eight years older; see also Lin, 2012; Sunseri, 2003). Also, in line with prior research, all three indicators of placement instability – duration in care, number of placements, and number of removals – were related to increased risk of running away (Bowden & Lambie, 2015; Courtney & Zinn, 2009; Lin, 2012). The present findings showed that children who ran away were in their current foster care placement for an average of four fewer months than children who did not runaway, compared to an average of seven fewer months in Lin's study. Similarly, children who ran away had an average of four more placements and more removals from their family of origin than children who did not runaway. This is consistent with research by Lin (2012) and Clark et al. (2008) which demonstrated that multiple placement settings increased the risk of running away; however, the most salient indicator of placement instability both here and in Lin's research was number of removals.

Regarding 10-year trends in running away from care, findings first showed that the percent of children in foster care who ran away steadily declined from about 1.4% in 2010 to less than 1% in 2019. Further, the profile of predictors of running behavior was overwhelmingly stable – females, children of color, children with substance use or behavior problems, older children, and those with greater placement instability were more likely to run from care – however, some notable exceptions were identified. For example, over the 10-year period running behavior among Asian children dramatically reduced, and the relationship between disability and running behavior was intermittent and in some instance changed directions over time.

While these data are limited in their ability to make causal inferences regarding changes in prevalence and predictors of running behavior, national efforts to reduce disparities in foster care have possibly contributed the noted decline. For example, a series of pieces of federal legislation (e.g., Multiethnic Placement Act of 1994, Family First Prevention Services Act of 2018) have supported a national shift in foster care system priorities to focus on reunification between children and families of origin. Additionally, state legislatures have taken responsibility to reduce racial disparities in the foster care system—specifically, 29 bills in 19 states (NCSL, 2021). Given that children of color are most likely to run away from foster care, the steady decline in running behavior may be a product of efforts to reduce racial disproportionalities.

5.1. Limitations and areas of future research

While the present research provided a much-needed update to the prior national-level research on running away from foster care, several limitations should be noted. First, the AFCARS consists of administrative data collected from 50 individual states and the District of Columbia and thus is vulnerable to inconsistencies in the definitions used and differences in standards for collection and measurement across state systems. The very nature of such a large data collection effort comes with risks for untraceable variation and potential errors. For instance, there were some abnormally high values on certain variables; however, consultation with the statisticians at NCANDS indicated that these outliers should be accepted as true values. It is worth noting that we conducted sensitivity analyses to ensure that these few outliers did not impact the presented estimates. Second, these data reflect a point-in-time count of profiles for children in foster care. In other words, these data do not represent every instance of running away for every child in foster care annually, and thus provide a conservative estimate of the true scope of this issue. In this regard, these data do not allow for the tracking of a child's prior history of running away, nor does it include potentially important risk factors such as the placement setting

from which a child ran away or LGBTQ+ identity. In addition, these data do not allow for a direct test of *why* children had run away from care, and relatedly, why the rates of running from care declined. Longitudinal analysis of children who run away from foster care is a critical area for future research but will require changes to how the AFCARS data is collected and reported. In addition, further analysis of the impacts of efforts to reduce racial disparities in foster care on running away from care is sorely needed, as children of color are most likely to run from care. Understanding the contextual reasons that predict running away are paramount to developing effective prevention and intervention programming.

Finally, the AFCARS data only identifies children as having run away (i.e., as one of the AFCARS placement settings). There is no distinction for children who are "missing from care" (i.e., the youth has been reported as a missing person) even though it seems unlikely that the reason or reasons a child is not present in placement is often known, i.e., that they ran away. This distinction as a runaway rather than a missing child minimizes the role of individual foster caretakers and the larger system regarding the supervision and welfare of children in foster placements and likely mischaracterizes the context in which many children leave or are forced from their placements (e.g., due to violence or victimization, coercion by predatory adults) (Lacey, 2019). Further, children labeled as a "runaway" are at risk for delinquency status and involvement in the youth justice system which may have a host of negative consequences and ripple effects (Lacey, 2019). Future research must focus on how and when a child is identified as a missing person rather than a runaway and whether and how this distinction is made in administrative records. Given the limitations of current data systems it is impossible to know the scope of missingness among children in foster care. Finally, research focusing on missing persons has found that American Indian/Alaska Native and African American youth are at particular risk of going missing (Richards, Wright, Nystrom, Gilbert & Branscum, 2021). Given the disproportionate involvement of children of color as both foster children (U.S. Department of Health and Human Services, 2018) and children who have run away from foster care, future research must consider the role of system involvement in research on missingness among children and the implications for prevention and intervention (see Nystrom et al., 2022).

5.2. Policy implications

Despite these limitations, there are six important policy implications for foster care services, practitioners, and researchers. First, the present analysis shows that of the variables examined, racial identity is the strongest predictor of running away from foster care with African American and Hispanic youth at particular risk for running behavior. These findings must be considered within the larger context of foster care experiences for children of color. Prior research shows that children of color are disproportionately involved in the foster care system (Dworsky et al., 2018; Wulczyn, 2020) and are often removed from their families of origin due to behaviors deemed to be neglectful such as inadequate nutrition or housing (U.S. Department of Health and Human Services, 2018). However, these neglectful behaviors are also synonymous with poverty suggesting that families may be better served by supportive services rather than removals. Second, prior research shows that African American children are overrepresented in group homes and institutions rather than family foster homes (Biehal & Wade, 2000), which may at least partially explain the current findings as children are more likely to run from group homes (Nystrom et al., 2022). Likewise, most foster caregivers are White and thus it is likely that even when children of color are placed in family foster homes, they are placed with caregivers of different racial and/or ethnic identities which may negatively impact the caregiver's ability to serve the child in a culturally competent way (Courtney et al., 2005; Iglehart, 1994). Taken together, policies that address the disproportionate representation of children of color in foster care as well as their disparate representation in group settings and with foster families that have different racial/ethnic identities will also likely address disproportionate rates of running away among children of color.

Foster care services should take time early on to identify the reasons why a child might run away from foster care placement and provide preventative intervention measures. As noted by Lin (2012) older children are more likely to know how to run and where to go. In addition, children who are older when they enter foster care have likely enjoyed significant autonomy in their families of origin and may have served as the caretaker for siblings or other family members. As such, new rules in a foster care setting limiting where they can go, when, and with who are often met with resistance (see Courtney et al., 2005). Further, adolescence is a time when individuals begin to assert their autonomy and question rules and authority. Thus, making adolescents an active part of placement decisions as well as negotiating placement plans regarding rules and responsibilities (e.g., curfews, chores) with the child and caregiver will likely reduce the likelihood of running away (see Clark et al., 2008; Michael, 2005).

Fourth, and relatedly, factors that are predictive of running away have been contextualized in the literature as *running to* and *running from* behaviors. Courtney et al. (2005) cite those children leave placements because they are running *to* families of origin, friends, and romantic partners. In this regard, it is unsurprising that children were more likely to run away when removed from single-parent households of origin compared to dual-parent households (Lin, 2012). One reason for this is the child may fill a caretaker role to their sole parent or a sibling(s). Although these data did not allow for examination of siblings and separation from siblings, prior research shows that children in foster care who remain with siblings are less likely to run from care (Courtney et al., 2005). Placing siblings together when possible and helping to maintain children's relationships with their families of origin may reduce running behavior. Further children were more likely to run away when the reason they were removed cited neglect, child substance abuse, child behavior problems, and abandonment which could be due to combination of *running to* and *running from* behaviors that contextualize their rationale for leaving care (Courtney et al., 2005; Crosland, Joseph, Slattery, Hodges & Dunlap, 2018; Finkelstein et al., 2004). Thus, ensuring that caretakers are adequately trained to support children with substance abuse and/or mental health challenges and providing supportive services to children who are most at-risk should reduce running from care.

Lastly, the AFCARS data does not distinguish children who "runaway" and children who are "missing from care," which is problematic because there is no way to know, prospectively, if leaving care was done so on their own or under the influence or harm of

another. Put another way, this process assigns a status offense to children whose motivations for not being present in their foster placement are unclear. Subsequently, assigning a runaway status obscures important placement-level and systemic-level factors that underpin why the child is not present in their foster placement (e.g., trafficking, abuse, leaving to unite with parents or siblings) and may have ripple effects for the child regarding the youth justice system.

6. Conclusion

Considering the limited research on the prevalence and predictors of running behavior among children in foster care, the current study provides a 10-year updated examination using national data on foster-care involved children. In this regard, the prevalence of children running from care has steadily declined since Lin's (2012) prior analysis of 2009 data. Further, there was relative stability in the predictors of running behavior across the 10-year study period, with few notable exceptions. Importantly, racial identity remained the strongest predictor of running away from foster care, with African American and Hispanic children experiencing the highest risks; child substance use was also a consistent and strong predictor of running from care. In light of prior research contextualizing why children run from foster care as well as emerging research on the prevalence of youth of color (Richards et al., 2021) and youth of color in foster care among missing persons cases (Nystrom et al., 2022), future research and practice would be likely better served by shifting terminology from children who are "run aways" to those who are "missing from care".

Declaration of competing interest

The authors have no conflict of interests to declare.

Acknowledgements

None.

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Meeting 3 – Jan. 4, 2023

Materials

Missingness Among Children in OOH Placement

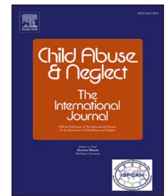
University of Nebraska Omaha

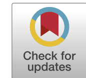
Child Abuse & Neglect 134 (2022) 105874

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg





Examining missingness among children in out-of-home care placement in Nebraska

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A R T I C L E I N F O

Keywords:
Foster care
Running away
Missingness

A B S T R A C T

Background: Little is known regarding the prevalence and context of missingness (i.e., being reported as a missing person) among children in out-of-home (OOH) care.
Objective: The present research examines the relationship between missingness and OOH care placements as well as predictors and case contexts of children missing from OOH care.
Methods: Point-in-time count data of reported missing persons in Nebraska and administrative records on children's OOH placements are used. Bivariate significance tests examine group differences; case contexts are explored through content analysis of OOH case reviews.
Results: About 30 % of Nebraska's missing children are in OOH care. Bivariate tests show that children missing from OOH care are older and are more likely to be Black and less likely to have their race listed as "unknown" than children missing from their families of origin. Children in OOH who are missing are also more likely to be in group care, on probation, and have greater placement instability compared to children in OOH care who are not missing. Case contexts of missingness include unmet substance use and mental health challenges, experiences with violence and victimization, and few bonds to school.
Conclusions: Screening and interventions for high-need children in OOH care and their caregivers are necessary to prevent children from going missing from placements.

1. Introduction

While prior research has explored running away from foster care (e.g., Branscum & Richards, 2022; Lin, 2012), little is known regarding the prevalence and context of missingness (i.e., being reported as a missing person) among children in out-of-home (OOH) care placements. In fact, although the problem of missing persons has gained national attention – especially regarding missing Native American and African American persons (e.g., Richards et al., 2021) – the term missing is rarely used to describe children who are not present at their OOH placements. Instead, prior research, as well as state and administrative departments and data systems, often classify these children as runaways (Lacey, 2019). Whether classified as runaways or missing persons, children who are not present at their OOH placement are at greater risk for criminal or sexual victimization, drug or alcohol abuse, criminal activity, and human trafficking, among other risks (Bowden & Lambie, 2015; Clark et al., 2008; Gambon et al., 2020; Latzman et al., 2019). Using data from

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https://doi.org/10.1016/j.chiabu.2022.105874
Received 7 February 2022; Received in revised form 14 July 2022; Accepted 4 September 2022
Available online 8 September 2022
0145-2134/© 2022 Published by Elsevier Ltd.

a point-in-time count of reported missing persons and administrative records on children's OOH placements, the present research examines the relationship between missingness and OOH care placements. In addition, for children who were in OOH care placements, individual- and case-level factors are assessed to explore the predictors of missingness and the case contexts of children missing from OOH care.

2. Predictors of running away from OOH care placements

Prior research has established that a portion of children in OOH care are not present in their placements at any given time, (e.g., have run away); however, estimates regarding the prevalence of running away among children in foster care vary widely from less than 2 % (Branscum & Richards, 2022; Lin, 2012) to 71 % (Biehal & Wade, 1999) across different samples and jurisdictions. Studies have identified a range of individual risk factors thought to increase the likelihood a child will run away from placement, including the child's age, gender, race, substance use, and mental health history, among others. Regarding age, studies suggest that teenagers (those age 13 and older) are more likely to run from care than younger children (Branscum & Richards, 2022; Courtney et al., 2005; Courtney & Zinn, 2009; Dworsky et al., 2018). In addition, research suggests that children who are removed from their home at an older age are more likely to run than those who are younger at first removal. For example, Lin (2012) found that children who run from placement are on average 5 years older at their first removal than those who do not run.

Females are significantly more likely to run than males (Branscum & Richards, 2022; Dworsky, Wulczyn, & Huang, 2018; English & English, 1999; Fasulo et al., 2002; Kim et al., 2015; Sunseri, 2003). Studies have also shown that children of color are also more likely to run from their placements (Branscum & Richards, 2022); however, studies have been inconsistent regarding whether children from a particular racial or ethnic group are more likely to run away. For example, Wulczyn (2020) found that African American and Hispanic children are more likely to run from placement than their White peers. Similarly, Lin (2012) found that African American girls are most likely to run. In contrast, Nesmith (2006) found that American Indian children had twice the odds of running away as White children.

Prior studies have also suggested that children with substance use disorders are more likely to run away from foster care than those without substance use disorders (Branscum & Richards, 2022; Courtney et al., 2005). Likewise, mental health diagnoses have been associated with running away from foster care (Clark et al., 2008; Courtney et al., 2005; Courtney & Zinn, 2009; Kim et al., 2015). Further, Lin (2012) found that foster children who ran away from their placements had higher rates of disabilities (including mental health disabilities) than foster children who did not run away (but see Branscum & Richards, 2022).

In addition to individual-level risks, several placement-level factors associated with running away from a foster care placement have been identified. For example, children in group placements are more likely to run away from care than those in family placements (Courtney et al., 2005; Witherup et al., 2008), as are children placed with a non-relative as compared to those placed with a relative (Courtney et al., 2005). Placement instability has also been linked to running away: children with 2 placements or fewer are less likely to run from care compared to children with more than 2 placements (Children's Bureau U.S., 2018); higher numbers of separations from home are also related to an increased likelihood of running from placement (Branscum & Richards, 2022; Clark et al., 2008; Courtney et al., 2005). Finally, case plan goal may be connected to running from a foster care placement. Kim et al. (2015) found that children whose long-term care plans included foster care and/or whose case plan goal was not reunification were more likely to run than those with plans for shorter stays in foster care, family reunification, or adoption.

3. Why children run from OOH care

There are myriad reasons a child might run from a foster care placement, and studies tend to agree that running is a coping behavior for children in care (Lin, 2012). Collectively, scholars note that children run away because they are either *running to* or *running from* someone or something (Courtney et al., 2005; Crosland et al., 2018; Crosland & Dunlap, 2015). For example, Courtney et al. (2005) examined administrative data for over 14,000 children who ran from care over the course of 10 years between 1993 and 2003 and interviewed 42 children who had run away from foster care and then returned. Running behavior was organized into four broad categories: (1) running to family of origin, (2) returning to friends and the streets, (3) touching base and maintaining relationships, and (4) running at random.

Similarly, a review by Crosland et al. (2018) classified the reasons children reported running from their foster placements using this dichotomy; though they used the terms *access* (i.e., running to) and *avoidance* (i.e., running from). They found that children ran to positive social supports such as family and friends and ran from negative social interactions, such as those with foster care placement staff and peers that left them feeling unloved or unvalued. The desire for “normalcy” was another key reason children ran away. In interviews, children reported running to friends, parties, and extracurricular activities that made them feel normal (i.e., activities that a child not in OOH care would experience).

Although prior research has explored the risk factors and context for running away from foster care, the present research aims to shed light on the prevalence and context of *missingness* among children in OOH care placements. On January 20, 2020, a point-in-time count of missing persons in Nebraska was conducted and uncovered that two-thirds of Nebraska's reported missing persons were children (i.e., in Nebraska, minors aged 18 years or younger) (see Richards et al., 2021; Sutter et al., 2020). Using data from this point-in-time count of reported missing persons and administrative records on children's OOH care placements from the Nebraska Foster Care Review Office, the present research examines the relationship between missingness and OOH care placements among children who had been reported missing in Nebraska. Then, among children who were in OOH care placements, individual and case-level factors were assessed to explore predictors and contexts of missingness. The following research questions guided the analyses:

RQ1: Among children who had been reported missing, what was the prevalence and context(s) of children who were in OOH care placements compared to children who were not in OOH care placements?
RQ2: Among children who were in OOH care placements, who is missing from the OOH care placements (i.e., what individual- and case-level factors predict missingness among children in out-of- home care)?
RQ3: What is the context(s) of children missing from OOH care placements?

4. Methods

4.1. Data and sample

Data were drawn from two distinct sources (1) a point-in-time count of persons officially reported missing in the state of Nebraska on January 20, 2020, and (2) administrative records from the Nebraska Foster Care Review Office (FCRO) for children described as in an OOH placement or having just been in an OOH care placement and nearing permanency completion on January 20, 2020. Data for the point-in-time count of officially reported missing persons was collected from three publicly available data sources: (1) the Nebraska Missing Persons List (NMPL), (2) the National Missing and Unidentified Persons System (NamUs), and (3) the National Center for Missing and Exploited Children's (NCMEC) missing persons list. On the day of the point-in-time count, January 20, 2020, the NMPL database was accessed and the list of all persons missing from Nebraska on that date and their associated case information were recorded in a SPSS database. These data were then cross-checked against the national lists from NamUs and NCMEC and any additional persons missing from Nebraska that were not reflected on the NMPL were added to the dataset. Data collection was conducted by three Ph.D. level graduate assistants (see Richards et al., 2021 for a full description of the study design and methods).

The list of names of missing children identified in the point-in-time count of officially reported missing persons was then cross-checked with the administrative records from the FCRO. The FCRO is an independent state agency responsible for the oversight of the permanency, safety, and well-being of all children in OOH care in Nebraska. The FCRO defines OOH as "… 24-hour substitute care for children placed away from their parents or guardians and for whom a state agency has placement and care responsibility" (FCRO, 2021, p. 4). This term includes OOH placements due to child abuse or neglect as well as delinquency status.

The FCRO's role is to independently track children in OOH care, collect and analyze data related to these children, and make recommendations on conditions and outcomes, including any needed corrective actions. The FCRO is statutorily mandated to maintain an independent tracking system of all children in an OOH placement in the state. The tracking system is used to provide information about the number of children entering and leaving care as well as other data regarding children's needs and trends in OOH placements, including data collected as part of the FCRO case file review process.

During each FCRO case file review, an FCRO staff person (System Oversight Specialist) facilitates the monthly meeting of 4–10 specially trained community members from a variety of disciplines (local board). The board determines each reviewed child's needs based on the summary document provided by the System Oversight Specialist that contains information from the files of agency(s) involved in the child's case (i.e., DHHS, Probation, or both) along with any input received from the parties to the child's case, other research, and the system's actions to date. From this analysis, the board makes recommendations for next steps for the child's case. The System Oversight Specialist formalizes the review findings and recommendations with rationale into a document that is then shared with the legal parties on the child's case, including the Court.

The first FCRO case file review after children's removal from the home is usually scheduled to occur at approximately 6 months post-removal. Children are then re-reviewed about every 6 months for as long as they remain in OOH care. Whenever possible FCRO reviews are scheduled to occur so that the formal review document is received by the court and legal parties in time to be considered and acted upon before the child's next court hearing.

A Ph.D. level graduate student research assistant was embedded at the FCRO to serve as a data intern for this special project on missingness among children who had been in OOH placements in Nebraska. The data intern worked closely with FCRO staff to develop the deidentified project dataset and to clean and analyze these data. The study design was reviewed by the University of Nebraska Institutional Review Board and deemed a program evaluation, not human subjects research.

4.2. Measures

4.2.1. Officially reported missing persons data

For each case, the *first and last name*, *age at missing*, *sex* (0 = male, 1 = female), *race* (Uniform Crime Report [UCR] racial categories: 1 = White, 2 = Black, 3 = American Indian/Alaska Native, 4 = Asian or Pacific Islander, or 5 = Unknown), and *date of missingness* was recorded. *Years missing* was calculated by subtracting the date the child went missing from the date of data collection (i.e., January 20, 2020).

4.2.2. Foster care review office data

Cases were de-identified using a unique *FCRO ID number*. For each case the following demographic data was collected, *age* was calculated by subtracting the date of birth from the date of data collection (i.e., January 20, 2020), *sex* (0 = male, 1 = female), *race* (FCRO racial categories: 1 = White, Non-Hispanic; 2 = Black, Non-Hispanic; 3 = American Indian or Alaska Native, Non-Hispanic; 4 = Asian/Native Hawaiian, Non-Hispanic; 5 = Hispanic; 6 = Multiracial, Non-Hispanic; 7 = Other Race, Non-Hispanic; and 8 = Unknown Race) and *date of missingness*.

Times in care (*lifetime*) included the number of care episodes over the child's lifetime, *number of placements* (*lifetime*) included the

number of placements over the child's lifetime, and *days in current placement* indicates the number of days the child had been in the placement type they were assigned on January 20, 2020. *Placement at point in time* (*PIT*) indicates the type of placement the child was assigned on January 20, 2020 (see Appendix for PIT definitions) (1 = foster home, relative or kinship; 2 = foster home, non-relative; 3 = group home; 4 = institution (i.e., medical hospital, psychiatric facility, etc.); 5 = supervised independent living; 6 = trial home visit; 7 = detention facility; 8 = near permanency placement (i.e., adoptive home approved/licensed). *Agency involvement* comprised the state agency or agencies responsible for supervising the child's OOH placement as of January 20, 2020 (1 = Nebraska Department of Health and Human Services/Child and Family Services, 2 = Nebraska Department of Health and Human Services/Child and Family Services and Probation, 3 = Nebraska Department of Health and Human Services/Office of Juvenile Services and Probation, 4 = Nebraska Department of Health and Human Services/Office of Juvenile Services, and 5 = Probation Only. *Reviewed* indicated whether the child had a FCRO review within 6 months of January 20, 2020 (0 = no, 1 = yes).

4.3. Analytic plan

Analysis proceeded over several phases. To begin, the population of children who had been officially reported missing as of January 20, 2020, was compared with FCRO administrative records on January 20, 2020, to identify which children were in an OOH care placement when they were reported missing. Next, the population of children who were in OOH care placements on January 20, 2020, was examined and children who appeared in the population of officially reported missing persons were compared to children who did not appear in the population of officially reported missing persons. Then, the subsample of children who (1) had been officially reported missing from their OOH placements and (2) had a review from the FCRO was compared with the subsample of children who had been officially reported missing from their OOH placements but had not had a review from the FCRO. For each of these analyses, descriptive statistics and bivariate means tests were estimated to identify significant differences between groups. Alpha was set at $p < .05$ for all quantitative analyses.

Finally, qualitative data from the case files for missing children in OOH care who had a FCRO review were examined to provide insight into the case contexts related to missingness. A doctoral level research assistant read each narrative review and coded the narrative regarding any situational factors related to running away (e.g., substance use, experiences with violence). Coding was guided by prior research regarding why children run from care (e.g., Courtney et al., 2005; Crosland et al., 2018; Crosland & Dunlap, 2015). Case contexts were not mutually exclusive: each identified factor for each case was coded, and thus, multiple factors could be associated with a child's case. The prevalence of each theme was calculated as a total frequency and percentage (see Table 4) and narrative examples of different contexts were included using pseudonyms.

5. Results

Regarding the population of children (i.e., minors, ages 18 years or younger) who had been officially reported missing in Nebraska as of January 20, 2020, the majority were male (52.00 %) and White (55.38 %) (see Table 1). Nearly one third was Black (28.08 %), while approximately 7 % were American Indian/Alaska Native or listed as an "unknown race", respectively. Missing children ranged in age from 3 to 18 years old and were 15.89 years old on average (SD = 1.85). They had been missing from 0 to 15 years and 0.52 years on average.

The first research question concerned the relationship between missingness and OOH care among children in Nebraska. To address

Table 1
Descriptives for sample of officially reported missing children on 1/20/2020 and comparisons across children in out-of-home placements versus children not in out-of-home placements (*N* = 381).

	Total sample *N* = 381		Children in out-of-home placements *n* = 114		Children not in out-of-home placements *n* = 267		t/x^2 test
	N	%	*n*	%	*n*	%	
Sex							x^2 (1) = 0.003 p = .956
Female	183	48.00	55	48.25	128	47.94	
Male	198	52.00	59	51.75	139	52.06	
Age at missing	*M* = 15.89; *SD* = 1.85 Range = 3–18 years		*M* = 16.01; *SD* = 1.30 Range = 12–18 years		*M* = 15.84; *SD* = 2.04 Range = 3–18 years		t (322.447) = −1.045 p = .148
Race							x^2 (4) = 12.484 p = .014
White	211	55.38	56	49.12	155	58.05	
Black	107	28.08	43	37.72	64	23.97	
Asian	4	1.05	0	–	4	1.50	
American Indian/Alaska Native	30	7.87	11	9.65	19	7.12	
"Unknown race"	29	7.61	4	3.51	25	9.36	
Years missing	*M* = 0.52 *SD* = 1.56 Range = 0–15 years		*M* = 0.16; *SD* = 0.43 Range = 0–2 years		*M* = 0.67; *SD* = 1.82 Range = 0–15 years		t (327.355) = 4.320 p < .001

research question one, we crosschecked our population of missing children with data from the FCRO. Results indicated that nearly 30 % of children who had been officially reported missing as of January 20, 2020, were in an OOH care placement. Children missing from OOH care placements were statistically similar to children who were missing from their families of origin regarding age and sex; however, children who were missing from OOH care placements were statistically different from children who were missing from their families of origin regarding race and years missing. Specifically, children who were missing from OOH care placements were more likely to be Black whereas children who were missing from their family of origin were more likely to be listed as an "unknown" race. In addition, children who were missing from OOH placements were missing for significantly less time than children who were missing from their family of origin, an average of 0.16 years compared to 0.67 years, t (327.355) = 4.320, $p < .001$.

Research question two was concerned with the individual- and case-level factors predictive of being reported missing among all children in OOH care. To address this research question, we examined the FCRO records for all children who were in OOH care placements on January 20, 2020 ($N = 4103$) and compared children who had been officially reported missing ($n = 114$) with children who had not been officially reported missing ($n = 3989$) (see Table 2). Results showed no significant differences regarding sex across children who had and had not been officially reported as missing. Conversely, findings indicated that children who had been officially

Table 2

Descriptives for FCRO sample and bivariate comparisons between children who were missing from out-of-home placement and children who were not missing from out-of-home placement ($N = 4103$).

Variable	Total sample $N = 4103$		Missing from placement $n = 114$		Not missing from placement $n = 3989$		t/x^2 test
	N	%	n	%	n	%	
Sex							x^2 (2) = 0.404 $p = .817$
Female	1927	46.97	56	49.12	1871	49.60	
Male	2169	52.86	58	50.88	2111	52.92	
Age at PIT count	M = 10.17; SD = 5.91 Range = 0–19 years		M = 16.76; SD = 1.31 Range = 12–19 years		M = 9.98; SD = 5.89 Range = 0–19 years		t (277.834) = −43.958 $p < .001$
Race							x^2 (6) = 22.730 $p < .001$
Hispanic	817	19.91	24	21.05	793	19.88	
White, not Hispanic	1876	45.72	38	33.33	1838	46.08	
Black, not Hispanic	799	19.47	36	31.58	763	19.13	
American Indian/Alaska Native, not Hispanic	183	4.46	9	7.89	174	4.36	
Asian, Native Hawaiian and other Pacific Islander, not Hispanic	37	0.90	0	–	37	0.93	
Other race or unknown, not Hispanic	46	1.12	3	2.63	43	1.08	
Multiracial, not Hispanic	345	8.41	4	3.51	341	8.55	
Number of times in care, lifetime	M = 1.52; Median = 1.00 SD = 0.98; Range = 1–12		M = 2.59; Median = 2.00 SD = 1.66; Range = 1–8		M = 1.49; Median = 1.00 SD = 0.94; Range = 1–12		t (115.094) = −7.022 $p < .001$
Number of out-of-home placements, lifetime	M = 4.10; Median = 2.00 SD = 4.97; Range = 1–62		M = 8.89; Median = 7.00 SD = 7.65; Range = 1–37		M = 3.96; Median = 2.00 SD = 4.81; Range = 1–62		t (115.564) = −6.850 $p < .001$
Days in placement at PIT or last placement before missing	M = 199.49; Median = 134.00 SD = 208.45; Range = 4–2287		M = 103.52; Median = 59.00 SD = 134.96; Range = 5–919		M = 202.23; Median = 138.00 SD = 209.53; Range = 4–2287		t (129.087) = 7.553 $p < .01$
Placement at PIT or last placement before missing							x^2 (7) = 105.426 $p < .001$
Foster home (relative or fictive/kinship)	1575	38.39	14	12.28	1564	39.13	
Foster home (non-relative)	1156	28.17	32	28.07	1124	28.18	
Group home	236	5.75	19	16.67	217	5.44	
Institution	249	6.07	16	14.04	233	5.84	
Supervised independent living	43	1.05	3	2.63	40	1.00	
Trial home visit	389	9.48	1	0.88	388	9.73	
Detention facility	245	5.97	9	7.89	236	5.92	
Near permanency placement	210	5.12	20[a]	17.54	190	4.76	
Agency involvement at PIT							x^2 (5) = 244.286 $p < .001$
NDHHS/CFS only	3279	79.92	30	26.32	3249	81.45	
NDHHS/CFS and probation	149	3.63	16	14.04	133	3.33	
NDHHS, OJS, and probation	111	2.71	2	1.75	109	2.73	
NDHHS and OJS only	8	0.19	1	0.88	7	0.18	
Probation only	555	13.53	65	57.02	490	12.28	

reported missing were significantly older on average than children who had not been officially reported missing, 16.76 years old compared to 9.98 years old, t (277.834) = −43.958, $p < .001$. In addition, a statistically greater percentage of Black children were officially reported missing compared to not officially reported as missing, while a statistically lower percentage of White children were officially reported missing compared to not officially reported as missing, $x^2(6) = 22.730$, $p < .001$. Regarding placement stability, children who had been officially reported missing had greater numbers of episodes in care during their lifetime on average (2.59 versus 1.49), t (115.094) = −7.022, $p < .001$, and greater numbers of placements during their lifetime on average (8.89 versus 3.96), t (115.564) = −6.850, $p < .001$, compared to children who had not been officially reported missing. Further, children who had been officially reported missing had been in their current placement significantly fewer days than children who had not been officially reported missing, a median of 59 days compared to 138 days, t (129.087) = 7.553, $p < .001$.

Placement type was further explored by examining children's placement type on January 20, 2020, or among children was missing from care, their most recent placement type before going missing from care. Significant differences regarding placement type across children who had and had not been officially reported missing were identified, $x^2(7) = 105.246$, $p < .001$. Significantly greater percentages of children who were officially reported missing were in group homes, institutions, independent living placements, detention facilities, and near permanency placements, while significantly greater percentages of children who had not been officially reported missing were in relative/kinship foster home placements and trial home visits. Of note, of the 20 children who had been reported missing from a near permanency placement, all 20 had been returned home to their family of origin. Finally, there were significant differences regarding the types of agency supervision among children who had and had not been officially reported missing, x^2 (5) = 244.286, $p < .001$; significantly greater percentages of children who had been officially reported missing were under the supervision of Probation, while significantly lower percentages were under the supervision of Nebraska Department of Health and Human Services/Child and Family Services only.

Table 3
Descriptives for sample of missing children in out-of-home placements who had a FCRO review versus missing children in out-of-home placements who did not have a FCRO review (n = 114).

	Reviewed (n = 53)		Not reviewed (n = 61)		t/x^2 test
	n	%	n	%	
Sex					x^2 (1) = 2.218 p = .136
Male	23	43.40	35	57.38	
Female	30	56.60	26	42.62	
Age at PIT	M = 16.22; SD = 1.47 Range = 12–18		M = 16.29; SD = 1.14 Range = 13–18		t (97.505) = −0.274 p = .784
Race					x^2 (5) = 0.267 p = .998
Hispanic	11	20.75	13	21.31	
White, not Hispanic	18	33.96	20	32.79	
Black, not Hispanic	17	32.08	19	31.15	
American Indian/Alaska Native, not Hispanic	4	7.55	5	8.20	
Asian, Native Hawaiian, and other Pacific Islander, not Hispanic	0	–	0	–	
Other or unknown race, not Hispanic	1	1.89	2	3.28	
Multiracial, not Hispanic	2	3.77	2	3.28	
Listed as missing from care in FCRO at PIT	32	60.38	21	34.43	x^2 (1) = 1.048 p = .306
Number of times in care, lifetime	M = 1.98; Median = 2.00 SD = 1.12; Range = 1–5		M = 3.11; Median = 3.00 SD = 1.86; Range = 1–8		t (100.187) = −3.996 $p < .001$
Number of out-of-home placements, lifetime	M = 12.72; Median = 10.00 SD = 7.84; Range = 1–37		M = 5.57; Median = 4.00 SD = 5.72; Range = 1–31		t (93.771) = 5.484 $p < .001$
Days in placement at PIT or last placement before missing	M = 72.51; Median = 36.00 SD = 78.50; Range = 5–354		M = 130.45; Median = 76.00 SD = 165.46; Range = 13–919		t (88.278) = −2.438 p = .017
Placement at PIT					x^2 (7) = 39.222 $p < .001$
Foster home (relative or fictive/kinship)	13	18.31	1	2.33	
Foster home (non-relative)	30	42.25	2	4.65	
Group home	9	12.68	10	23.26	
Institution	7	9.86	9	20.93	
Supervised independent living	2	2.82	1	2.33	
Trial home visit	1	1.41	0	–	
Detention facility	5	7.04	4	9.30	
Near permanency placement	4	5.63	16	37.21	
Agency involvement at missing					x^2 (4) = 81.388 $p < .001$
NDHHS/CFS	28	52.83	2	3.28	
Probation only	7	13.21	58	95.08	
NDHHS/CFS & probation	16	30.19	–	–	
NDHHS/OJS only	–	–	1	1.64	
NDHHS/OJS & probation	2	3.77	–	–	

Research question three aimed to address the context of missingness among children who were in OOH placements. To address this question, in-depth qualitative case information for a sub-set of officially reported missing children whose case had a review by the FCRO ($n = 53$; 46.49 %) was used. However, it is important to note that children's cases are reviewed approximately every 6 months, not at random. Thus, missing children whose case had been reviewed by FCRO and missing children whose case had not been reviewed by FCRO first were compared to assess any identifiable differences (see Table 3 below). There were no statistically significant differences between the reviewed and not reviewed samples on sex, age, or race/ethnicity. However, the groups varied significantly regarding the number of times a child was in care during their lifetime: the reviewed sample had been in care an average of 1.98 times compared to 3.11 times for the non-reviewed sample, $t(100.187) = -3.996$, $p < .001$. Similarly, the reviewed sample had been in an average of 12.72 different placements during their lifetime compared to 5.57 placements for the non-reviewed sample, $t(93.771) = 5.484$, $p < .001$. Children in the reviewed sample also had significantly fewer days in their placement on January 20, 2020, than children in the non-reviewed sample, a median of 36 days compared to a median of 76 days, $t(88.278) = -2.438$, $p = .017$.

Analyses also revealed significant differences between the two groups regarding the placement types from which they had gone missing, $x^2(7) = 39.222$, $p < .001$. For example, in the reviewed sample, children were most likely to go missing from either relative or non-relative foster homes, while in the non-reviewed sample children were most likely to have gone missing after being returned home or from a group home or institution. Among the 53 children who were officially reported missing and listed as "missing from care" in the FCRO records, 60.38 % were among the review sample, $x^2(1) = 1.048$, $p = .360$. Finally, significant differences were found between the two groups regarding which agency or combination of agencies had supervision of the child when they went missing from care, $x^2(4) = 81.388$, $p < .001$. Children in the reviewed sample were most likely to be under the supervision of Nebraska Department of Health and Human Services/Child and Family Services only or in combination with Probation while children in the non-reviewed sample were most likely to be under the supervision of Probation only.

To examine the context of missingness among children in OOH care, case summaries for children who had a FCRO case file review were analyzed ($n = 53$). Children were anonymized with pseudonyms. This analysis was informed by the body of previous research suggesting that children in foster care often "run" to something/someone or from something/someone as well as important situational factors (i.e., experiences with violence, substance use) (e.g., Courtney et al., 2005; Crosland et al., 2018; Crosland & Dunlap, 2015). The range of case contexts identified in case file reviews are presented in Table 4. Case contexts were not mutually exclusive such that each factor related to the missingness episode identified in a child's case file was coded and included in the frequencies.

To begin, case summaries revealed that 2 children (3.77 %) ran to a trusted adult, while no children in the present sample ran to a boyfriend/girlfriend. Six (11.32 %) case summaries suggested the child ran from placement as a coping strategy: repeatedly leaving a placement had become an established pattern of behavior for these children. For example, one summary notes that "Matt has shown in the past that he does not have good coping skills when he is upset or feels out of control. He has not taken any steps to learn any new coping … [he] has expressed a desire to stop running, but he has repeatedly not been able to control his impulses and has run anyway".

Beyond the "running to, running from" dichotomy several other key factors related to missingness were identified. The most prevalent factor was the role mental health challenges seemed to play in the lives of missing children who were in an OOH placement. Analyses revealed that in 45 of the 53 (84.91 %) case files reviewed the child was either in need of or participating in mental health services. Often, missingness was the reason that a child's mental health care was not being properly managed. When a child went missing their services were terminated and if they returned to care, the continuity of care across service providers was challenging: a child may not be able to return to the same counselor, therapist, and/or physician. Thus, any progress made, or trust built prior to their missingness may be lost and the process of assisting the child must start from the beginning.

Further, 16 case summaries (30.19 %) revealed that the child was mental health treatment resistant. For example, a case summary may indicate treatment resistance with a note such as "Morgan is not participating in therapy services and is resistant to participating in services," or "Michael is unwilling to participate in therapy services". Treatment resistance included resistance or refusal to

Table 4
Case contexts related to missingness among children in out-of-home placements ($n = 53$).

	n	%
Running To…		
A trusted adult	2	3.77 %
Running from…		
As a coping mechanism	6	11.32 %
Children mental health challenges	45	84.91 %
Children treatment resistance	16	30.19 %
Placement not prepared for mental health challenge	5	9.43 %
Sex trafficking victimization	3	5.66 %
Children substance use	26	49.05 %
Children school problems		
Truancy/attendance issues	28	52.83 %
Behavioral issues	19	35.85 %
Permanency objective issues		
Children objects to placement	3	5.66 %
Violence in any placement	12	22.64 %
Victimization in any placement	6	11.32 %
Family of origin inappropriate contact	5	9.43 %
An adult knew where child was while missing	9	15.09 %

participate in therapy or other psychiatric counseling, refusal to consider taking recommended medications, or failure to remain medication compliant. Additionally, case summaries for 26 children (49.06 %) discussed substance use problems; however, only 7 children (13.21 %) were receiving services for substance abuse issues. Finally, 5 (9.43 %) summaries indicated that in at least one placement in the child's history the reason the placement was terminated was related to the child's mental health and that the child's behavior (e.g., running behaviors, acting out in school, etc.) was more than the foster caregivers felt they could handle.

Five children were suspected or documented victims of sex trafficking victimization, and 1 child was a suspected victim of labor trafficking (11.32 %). The implications of this victimization were discussed in three of the case summaries, and in one of the cases, the child's missingness from placement was linked to trafficking victimization directly. The summary indicated, "…it was reported to Probation that during Jenny's last event running, she was found in a hotel with adult males. There is a concern that she could have been abused or exploited by these men". At the same time, narratives suggested that children often did not recognize their experience as victimization. For example, one case summary read, "Sarah does not view herself as a victim and has not been agreeable to any interventions, despite law enforcement involvement". Additionally, one of the summaries revealed that a child had likely been a victim of labor trafficking; however, no further details were available for analysis.

Problems in school were another recurring theme in these case summaries. Irregular attendance in school was discussed in the case summaries for 28 children (52.83 %). Guardians reported that the children felt that they did not need to attend school, and it was common for the guardian to indicate that they had trouble getting the child to attend school. For example, one summary noted that, "Jeremy has changed schools a number of times due to his placement changes and he has a history of truancy. Even when he was in school, he usually refused to do his work, so he has failed most classes. He is so far behind in credits; he knows he won't be able to graduate so he is not motivated and doesn't see the point in trying." Another theme identified in relation to school was children's behavioral issues when they did attend school. Behavioral issues in school were indicated in 19 (35.85 %) case summaries. For example, one summary revealed that "Darius has been suspended on numerous occasions and has over 55 instances this school year which have resulted in disciplinary actions."

In addition to mental health and school problems, the third major area of concern identified in the qualitative analysis was children's permanency objective. In 3 cases (5.66 %) the summary indicated that the child did not agree with their stated permanency objective. In some instances, the child indicated that they had another preference for where or with whom they should live. For example, one summary indicated that "When asked what would make him successful, Allan responded with "living with mom". He indicates that things are going well in the current placement, but there is nothing better "than living with mom." However, in many cases the child simply objected to their current permanency objective.

In addition, some children objected to their permanency objective due to inappropriate contact from the family of origin. In 5 cases (9.43 %), a parent from the child's family of origin was contacting the child despite not being allowed visitation or contact by the courts. For example, one summary read, "All four children contact one another telephonically. It was discovered, the children's group chat included their mother, which was not being allowed due to lack of supervision". In these cases, this "false hope" of reunification became a significant issue for the child who might otherwise do well in their placement and/or resulted in negative behaviors from the child.

Violence and victimization in placement were also identified as a barrier to permanency for children. Six children (11.32 %) had committed violence in their placements, and each time there was violence, the child was moved to another placement. Primarily, this violence comprised of physical fights with other children in the placement or with the adult guardian. One example of violence in the placement in a summary read "She recently assaulted Mr. Smith twice. She broke his glasses but did not cause any injury to him. Anna broke a window". Additionally, 12 children (22.64 %) were victims of violence in a placement. In these instances, it is usually a family member of the child or a friend/relative of the adult(s) in the placement who is responsible for perpetrating the victimization. For example, one child's summary indicated that they had been sexually assaulted by a cousin while in a placement.

Finally, the analysis of the case summaries revealed that in 9 cases (15.09 %) there was evidence that someone, usually the case worker or a family member of the child, knew where the child was while they were missing from their placement. In 4 cases, a family member was aiding the child in staying missing. For example, one summary indicated "The relatives had harbored the children while they were on run and did not notify" and in another instance the summary indicated "Ms. Jones indicates she has consistent contact with Jason but is unwilling to disclose his whereabouts".

6. Discussion and implications

A significant body of prior research has examined the prevalence and context of children who run away from foster care (Branscum & Richards, 2022; Courtney et al., 2005; Lin, 2012; Witherup et al., 2008), however little is known about children who go missing from OOH care placements. The present exploratory study used unique data from a point-in-time count of missing persons in Nebraska and administrative data from the Nebraska Foster Care Review Office to address this gap in the literature. First, findings showed that nearly 30 % of children who had been reported missing in Nebraska were in OOH care placements. Missing children who were in OOH care placements had more complete data (e.g., a known race/ethnicity) and had been missing for shorter periods of time than children who were missing from their families of origin. These differences may be due to the available data and multiple people – case workers, foster caregivers, probation officers – who have responsibility for the safety and security of children in OOH care as well as the policies and procedures for reporting missing children. However, these policies and practices are largely unknown, and for example, among probation, not always publicly available. As such, additional research is needed to understand if policies and/or processes for communication between system actors regarding reporting children who are missing from OOH placements could be improved.

Further examination of the population of children who were in OOH care placements showed that 2.77 % were missing from care;

this finding is consistent with other research using point-in-time count data such as Lin's (2012) study showing that 2 % of children in the Adoption and Foster Care Analysis and Reporting System data were not present in their foster care placements (i.e., listed as a runaway). Regarding children's demographics, consistent with prior studies on children identified as runaways from foster placements, White children were underrepresented as missing from care while children of color were overrepresented as missing from care (Branscum & Richards, 2022; Lin, 2012; Nesmith, 2006; Wulczyn, 2020); American Indian/Alaska Native children were missing at more than 1.5 times their rate of representation in Nebraska's OOH care population, while Black children were missing at 1.62 times their representation. Similarly, children who were missing from OOH were older than children who were not missing (see Branscum & Richards, 2022; Courtney et al., 2005; Courtney & Zinn, 2009; Dworsky et al., 2018). However, diverging from the literature on running away from foster care showing that girls are more likely to run (e.g., Branscum & Richards, 2022; Dworsky, Wulczyn, & Huang, 2018; Kim et al., 2015; Sunseri, 2003), the present research found no gender differences regarding children who were missing from an OOH placement.

Regarding placement stability, consistent with prior research regarding children who are identified as runaways from foster care, children who had more times in care (Branscum & Richards, 2022; Clark et al., 2008; Courtney et al., 2005) or more placements (Branscum & Richards, 2022; Children's Bureau U.S., 2018) were more likely to be missing from care than children who had less episodes in care or had fewer placements. In addition, less time in a child's current placement was associated with missingness. Like prior literature, children who were missing from care were disproportionately missing from a group home or institution (Courtney et al., 2005; Witherup et al., 2008). Children in a relative or kinship foster home were underrepresented among missing children. Departing from the literature on children who run away from foster care (see Courtney et al., 2005; Witherup et al., 2008), children who had been returned home to their family of origin were also disproportionately missing. Indeed, while only 5.12 % of all children who were in OOH placements in Nebraska were in *any type* of near permanency placement at the point-in-time of study, 17.54 % of children who were missing from placements were missing from their family of origin after being returned home. These findings prompt questions regarding the decision-making process for reunification: Were these children returned too soon, were underlying factors related to prior episodes of missingness from care left unaddressed? Additional research is needed to better understand whether families have the necessary supports in place both before and after reunification to keep children safe and the family secure.

Finally, children who were missing from care were disproportionately under the supervision of Probation, either alone or concurrently with Nebraska Department of Health and Human Services/Child and Family Services. Prior research demonstrates that children who are under the supervision of probation, as well as "cross-over" youth (i.e., those children who are under supervision by both child welfare and youth justice agencies), often have significant needs including mental health, substance use, and trauma histories (Herz & Ryan, 2008; Young et al., 2015), factors that have also been associated with running away from care in previous literature (e.g., Branscum & Richards, 2022; Lin, 2012). However, the prevalence of these children among officially reported missing children may also be due to a heightened level of supervision compared to children in OOH care placements that are not supervised by probation. In practice, if a child who is in an out-of-home placement due to delinquency status is not present at their placement, they would be considered to have absconded from care which may obscure risks and needs that led to the child going missing from placement. Additional research must attempt to unpack (1) whether possible system-level policies yield at least some responsibility for these disparities as well as (2) focus on the underlying factors associated with missingness among children in OOH placements who are under the supervision of probation agencies.

Examination of children's FCRO file reviews shed some light on the underlying factors associated with missingness among the OOH care population. Specifically, among the reviewed sample, there was evidence that few children had bonds to school (i.e., through attendance or passing grades). In addition, there were high rates of mental health and substance use challenges coupled with low rates of reported receipt of mental health and/or substance use treatment services. These qualitative data suggested that for many children who were missing from care, the relationships between these risk factors and missingness was complex and likely moderated by significant levels of placement instability.

Children had experienced multiple placement changes, potentially because of behavioral issues including leaving their OOH care placements, which in turn, impacted opportunities to achieve in school and disrupted relationships with mental and behavioral health specialists. Changes in mental and behavioral health specialists also require youth to repeatedly (re)disclose trauma and victimization histories to these new care providers. Minimizing the number of times child victims of abuse must (re)tell their story to different system actors has been identified as a best practice in child abuse forensic interviewing (Jones et al., 2005). The present findings highlight the need to consider ways to minimize repeated disclosures for system involved children as they move care placements.

In addition, several children, all teenagers, reported leaving their placements to live with another caregiver whom they preferred. In these types of cases – cases where youth have repeatedly left an OOH placement for a preferred adult caregiver – system-level decision makers might consider whether optimal outcomes could be achieved by listening to the youth's placement preference and providing supportive services to this caregiver. Similarly, these findings suggest in some cases children's otherwise successful placements are disrupted by non-custodial parents, who for example, aid children in leaving their placements or provide children with misinformation regarding family reunification. Taken together these findings are in line with prior research on running away that suggests that children may run to preferred or trusted adults or caregivers (Courtney et al., 2005; Crosland et al., 2018; Crosland & Dunlap, 2015).

Findings further showed evidence consistent with prior research suggesting that children might run from a placement due to violence or victimization (Courtney et al., 2005; Crosland et al., 2018; Crosland & Dunlap, 2015). In some cases, there was evidence of abuse in the OOH care placement or suspicion or documentation of trafficking victimization. Prior research shows that children in OOH care experience higher rates of physical and sexual abuse (Euser et al., 2014) and exposures to violence (Turney & Wildeman, 2017) when compared to children living in biological families. Further, evidence suggests that children "on the run" from foster

placements may be particularly vulnerable to trafficking victimization (Latzman et al., 2019). The present findings highlight the need to consider victimization experiences as a risk factor for missingness among children who were in OOH placements and that a higher level of training for foster caregivers is likely needed to keep children who have experienced victimizations in a previous placement present in their next placement. Likewise, ways to improve children's connections with foster care providers should be considered. Finally, results prompt questions about whether the term "runaway" should be used to describe children who are missing from their care placements and how and when the distinction between "runaway" and "missing child" are made.

6.1. Limitations and future research

While the present study provided novel evaluation of missingness among children who were in an OOH placement, several limitations must be noted. To begin, these data stemmed from a point-in-time count of missing persons, and thus, did not capture children who went missing and were found before January 20, 2020, or went missing after January 20, 2020. In addition, the most detailed data (i.e., case file reviews) from FCRO were only available for children who had a recent file review, and reviewed children only included about half of the children who had been officially reported missing from their care placement. There are many reasons that children might not have a review, such as 1) reviews typically are not conducted for children in care less than 6 months, 2) processes for probation reviews make it difficult to add alternative cases if a child returns home prior to review, 3) priority is given to cases with upcoming court dates, and 4) many probation cases do not have court reviews, among others. As such, the qualitative data from the review sample was not representative of the total population of children who were missing from care placements.

Future research must continue to examine the linkages between going missing and OOH care placements. Recent research has identified the disparate impact of missingness in Black and Native American communities (Richards et al., 2021). Given the disproportionate involvement of Black and Native American children in the foster care system and among children identified as runaways from foster care (Branscum & Richards, 2022; Lin, 2012), these relationships must be further unpacked. Likewise, future research should examine the prevalence of children who identify as LGBTQ+ who are missing from an OOH placement as these children are disproportionately represented among foster children (Gambon et al., 2020). Finally, the present findings suggest that children with placement instability or who were in OOH care placements due to their delinquency status should be an explicit focus of additional inquiry as should the relationships between violence and victimization and missingness among children in OOH placements. Exploratory findings reported here should serve as a foundation for future, hypothesis-driven research using multivariate modeling.

7. Conclusion

While prior research has addressed predictors of running away from foster care, it is unclear how prior studies have made the distinction between children who are missing from care and children who have run away from care. The present study took a novel approach by examining the prevalence of children who had been officially reported missing within the population of children who were in OOH placements. Findings demonstrated that nearly one third of missing children were missing from state care and that these children were more likely to be children of color, to have spent more time in state care with less placement stability, and to be under probation supervision than children who were in OOH placements who were not missing from care. Future research and policy priorities must focus on ways to identify and intervene in the lives of children in out-home-placements before they go missing from care.

Funding information

Research reported in this manuscript was sponsored by the National Institute of Justice under NIJ Grant Number 75-CX-0014. The conclusions expressed in this study are solely those of the authors and do not necessarily reflect the views of the National Institute of Justice. Additional data collection, analysis, and writing were supported by a Graduate Research and Creative Activity grant from the University of Nebraska at Omaha.

Data availability

Data will be made available on request.

Appendix A

The following definitions for OOH placement types are used by FCRO. FCRO definitions align with definitions used by the Nebraska Department of Health and Human Services definitions, and some are defined in statute.

Relative placement/kinship foster home. Neb. Rev. Stat. §71-1901(9) defines relative placement [foster home] as one in which the foster caregiver has a blood, marriage, or adoption relationship to the child or a sibling of the child, and for Indian children they may also be an extended family member per the Indian Child Welfare Act. Per Neb. Rev. Stat. §71-1901(7) kinship home is defined as a home where a child or children receive out-of-home care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a preexisting, significant relationship with the child or children or a sibling of such child or children as described in Neb. Rev. Stat. §43-1311.02(8).

Non-relative foster home. A non-relative foster home. is a home which provides foster care to a child or children pursuant to a foster care placement as defined in Neb. Rev. Stat. §43-1301 and which does not qualify as either a relative or kinship placement.

Group home. Group homes provide care for four or more children and are not a foster family home as defined in Neb. Rev. Stat. § 71-1901, and are not facilities that specialize in psychiatric, medical, or juvenile justice related issues, or group emergency placements.

Institutions. Institutions include medical hospitals, psychiatric hospitals, psychiatric residential treatment facilities, other specialized treatment facilities, or emergency shelters.

Supervised independent living. Supervised independent living is for wards nearing the age of majority but who have not yet been emancipated and that are primarily living independently, including in college dormitories or in an apartment.

Trial home visits. Neb. Rev. Stat. §71-1301(10) defines trial home visits as temporary placements with the parent from which the child was removed and during which the Court and NDHHS/CFS remains involved. This applies only to NDHHS wards, not to youth who are only under Probation supervision.

Detention facility. A detention facility placement is operated by a political subdivision that exists primarily for juveniles with delinquency or law violation issues or youth who are held while waiting disposition of charges against them.

Near permanency placement. Near permanency placements include placements that have formally agreed to adopt or finalize a guardianship.

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Meeting 3 – Jan. 4, 2023

Materials

High-Risk Victim Tool User Guide

Colorado Department of Human Services

COLORADO
Department of Human Services

High Risk Victim Tool User Guide

Process
This Job Aid table describes the actions needed to add a High Risk Victim (HRV) tool into Trails.

Related Job Aids:
https://www.coloradocwts.com/trails-resource/trails-modernization

- Manage Human Trafficking Screen (tutorial)
- Human Trafficking- Manage Self-Reports (tutorial)
- Human Trafficking- Manage Credible Reports (tutorial)
- Human Trafficking - Generate Reports (tutorial)

Introduction

- The *DCW Worker* will be able to add an HRV tool/screen when there is concern that a youth on their caseload has experienced trafficking or is at risk of being trafficked.
- The HRV tool assists in informing treatment, and/ or systems response to at-risk youth.
- The HRV tool will not confirm if a youth is being trafficked
- The HRV tool may be used by local human trafficking Multi- Disciplinary Teams to help guide interventions

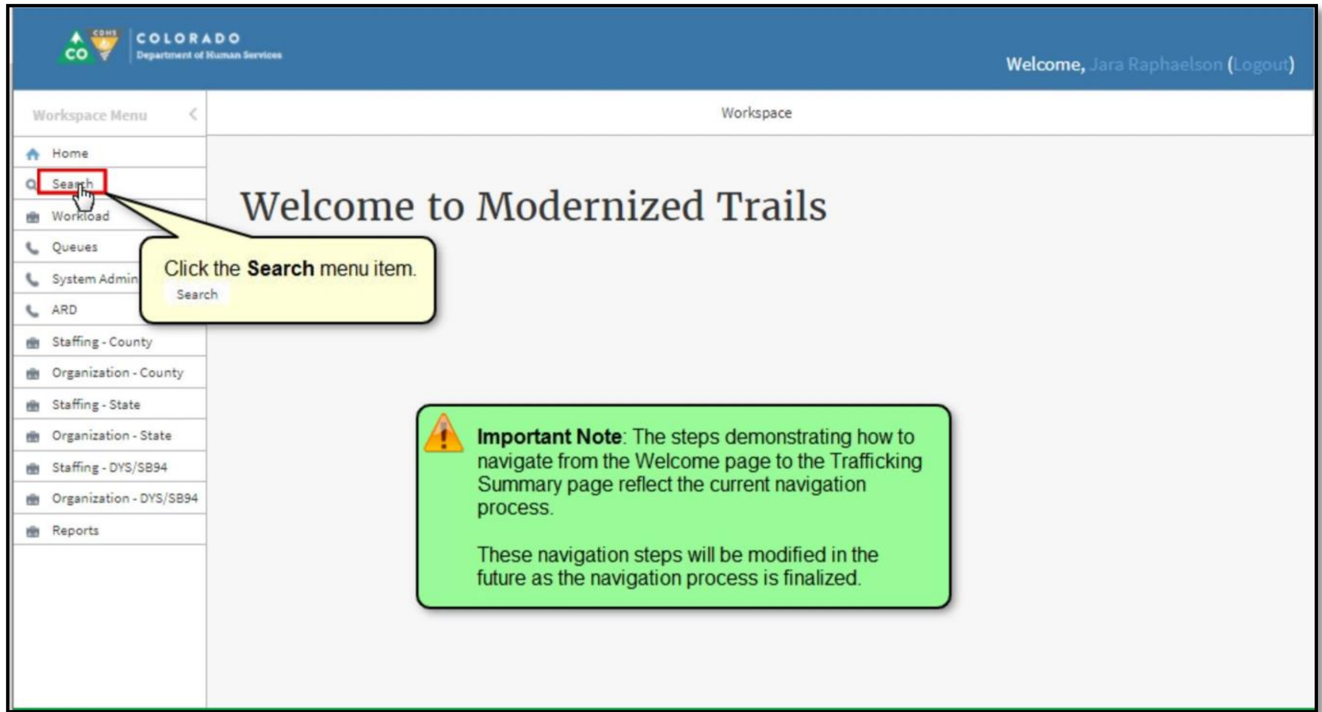
The Colorado High Risk Tool (HRV) must be completed:

1) In any open assessment or case, regardless of the program area, when the county department of human or social services has reason to believe a child/youth is, or is at risk of being, a victim of human trafficking

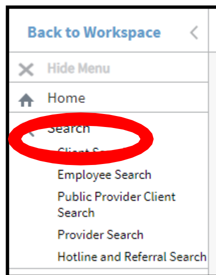
2) Any time a child/youth who is in the legal custody of the county department returns from a run

Access the HRV Tool through Trails Modernization platform using **CHROME** web browser. http://trails.state.co.us

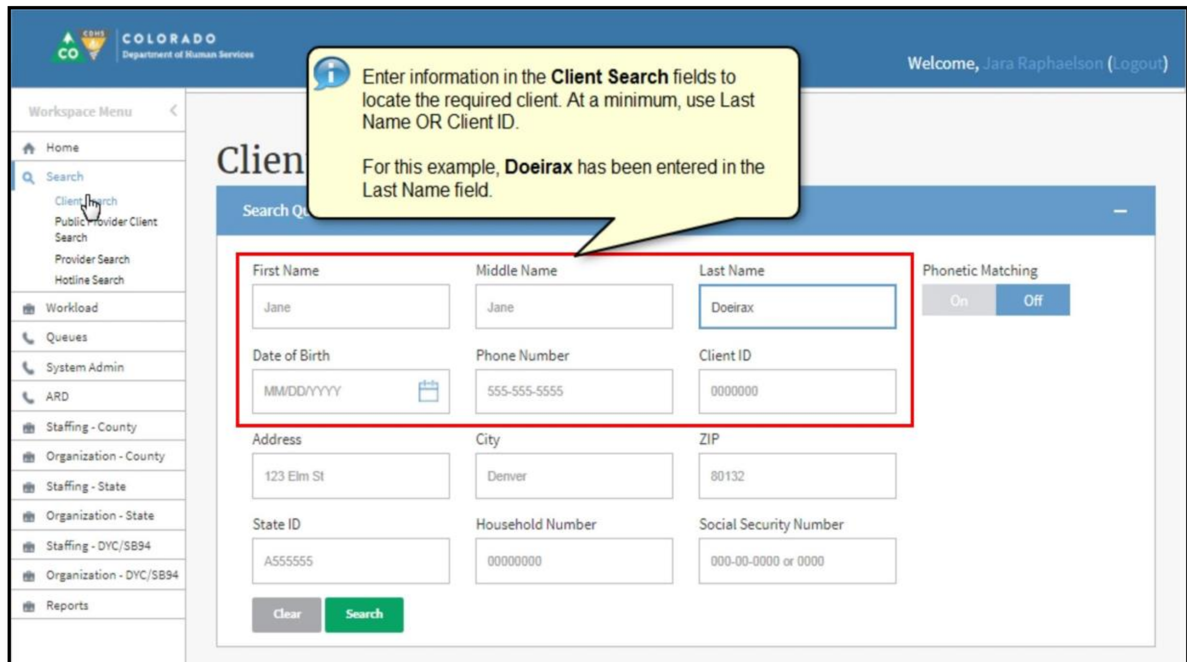
1. Select “Search” from the main page



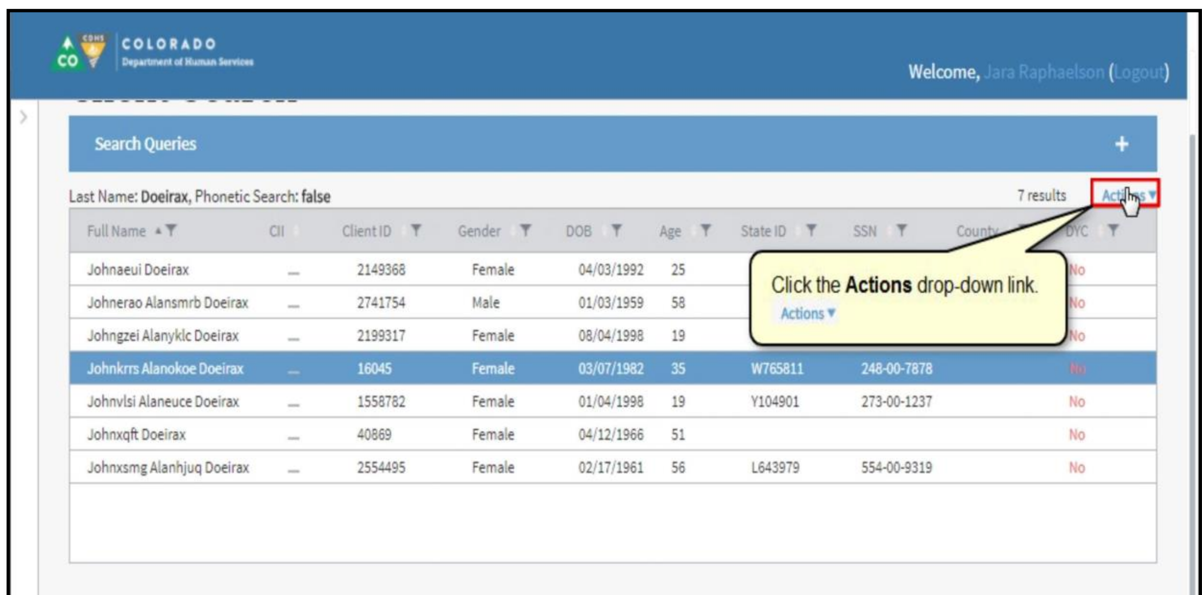
2. Select “Client Search”



3. Search for client using Name, Client ID, etc.

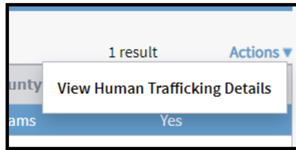


4. Select your client and select "Actions" from upper right hand menu

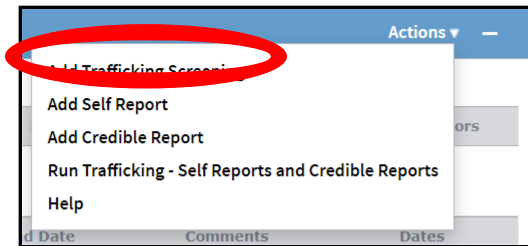


Full Name	CII	Client ID	Gender	DOB	Age	State ID	SSN	County	DYC
Johnaeui Doeirax	—	2149368	Female	04/03/1992	25				No
Johnerao Alansmrb Doeirax	—	2741754	Male	01/03/1959	58				No
Johngzei Alanyklc Doeirax	—	2199317	Female	08/04/1998	19				No
Johnkrrs Alanokoe Doeirax	—	16045	Female	03/07/1982	35	W765811	248-00-7878		No
Johnvlsi Alaneuce Doeirax	—	1558782	Female	01/04/1998	19	Y104901	273-00-1237		No
Johnxqft Doeirax	—	40869	Female	04/12/1966	51				No
Johnxsmg Alanhjuq Doeirax	—	2554495	Female	02/17/1961	56	L643979	554-00-9319		No

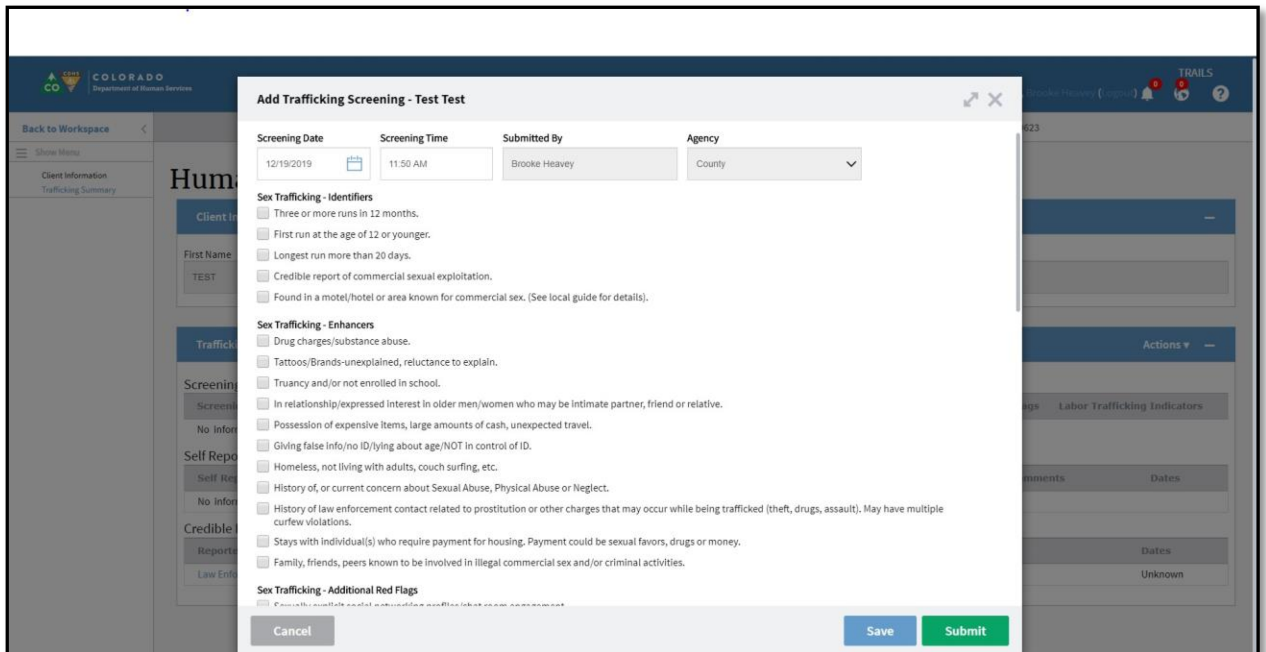
5. Select "View Human Trafficking Details"



6. Select "Actions" from upper right hand menu (for a second time) and select "Add Trafficking Screening"

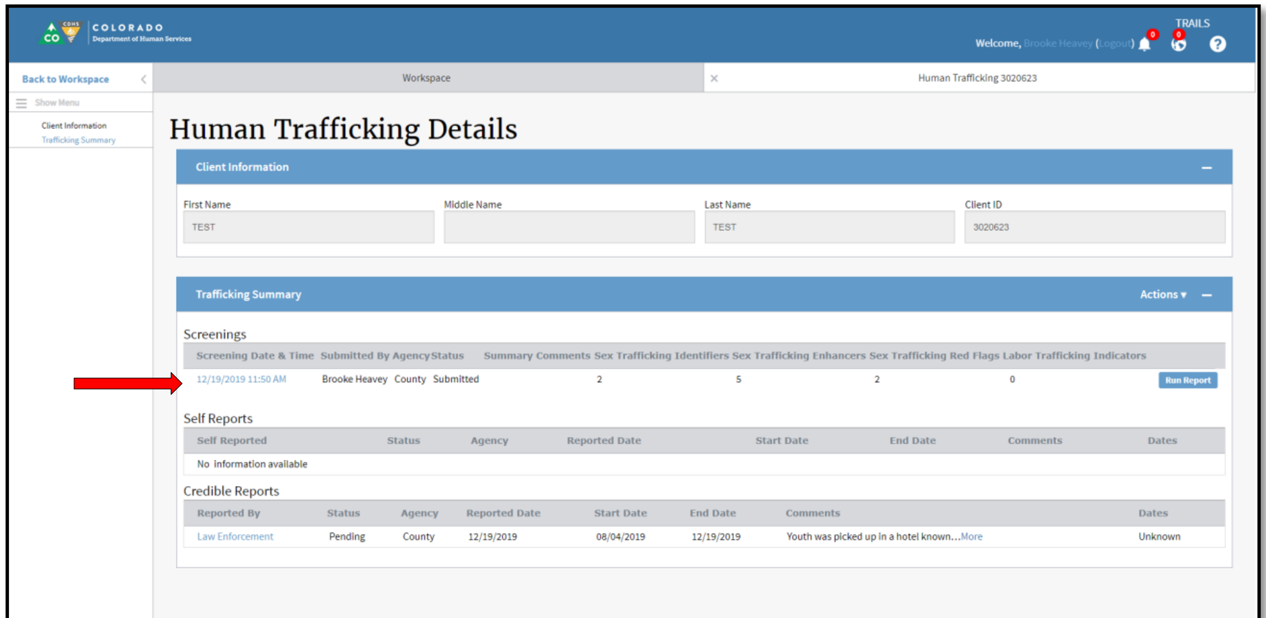


7. Select applicable trafficking indicators. A drop down box will open to populate additional information. Do not add "Self-report" or "In File". Add details about youth's experience.



8. Hit “Save” or “Submit”. “Submitting” will lock your entry, “saving” will allow for you to come back later and make edits. <u>Your HRV tools is not considered complete until it is submitted!</u>

9. All done! - You may review your trafficking screen and past trafficking screens here!



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Meeting 3 – Jan. 4, 2023

Minutes

CHILD PROTECTION OMBUDSMAN of COLORADO

Timothy Montoya Task Force | Meeting Three

Meeting Minutes

January 4, 2023 | 8am-11am

Meeting Recording

Facilitators: Keystone Policy Center

Time	Agenda Topic and Notes

8:00 am	• Announcing selection of Co-Chair
	  ○ Denver Public Safety Youth Programs program manager Beth McNalley is announced as the vice chair of the task force. McNalley oversees the city's Runaway, Outreach, Notification, and Intervention (RONI) program and Youth Denver Anti-Trafficking (DATA) Multidisciplinary Team.
	• Task Force Member outreach
	  ○ Chair Stephanie Villafuerte expresses that she will be scheduling 1-1 check-ins with each task force member.

8:05 am	• Legislative Charge
	  ○ Jennifer Superka introduces herself as new to the CPO team and shares how she plans to bring everyone's viewpoints together to understand the system and address the charges the task force has been charged with.
	  ○ Jennifer Superka notes that, though there are explicit things asked of the task force, this is an iterative and evolving process. Asks the task force to ask "what else do we need to know?" along the way.
	  ○ Superka shares with the task force the legislative charge separated out from the bill.
	• Task Force Syllabus
	  ○ The task force will be using a digital Dropbox to access the documents shared prior and in each meeting.
	  ○ The syllabus that has been drafted by the CPO team was shared with the task force:
	    ▪ Superka noted this would evolve as things progress, but wanted to provide an intuitive order that logically follows the discussions necessary along the way.

	▪ No questions from the task force.
8:20 am	Agency operations and processes: Bringing forward the task force's diverse perspectives and areas of expertise, members heard about the current procedures that agencies follow when a youth runs away from an out-of-home placement. Task force members representing the county human service agencies, treatment facilities and law enforcement each shared the processes their agencies follow by answering the key questions below. ● What happens when a child runs away? ○ Member Lynette Overmeyer from Mesa County: ■ Lynette notes she believes this is standard across the state per volume seven rules. ■ The placement notifies Law enforcement immediately. ■ The Child Protection Hotline, that entity gets a hold of the county if it's the hotline county connection center (HCCC) which is a state hotline (every county has their own). ■ The HCCC hotline ensures the missing child is reported to the National Center for Missing and Exploited Children (NCMEC) website. ■ Case workers, parents, and Guardian Ad Litem are notified the same day. ■ Next day, the court is notified. ○ Brandon Miller- Southern Peaks residential facility: ■ Procedures at his residential facility are standard. ● First contact is their referral team and their family. ● Contact the police. ● Tries to stay in visual contact until they lose sight in addition to verbal de-escalation. Notes the noise near his facility and the inability to go on private property can create challenges getting to the child. ● If sight is lost, they notify the police department and PD takes over from that point. Facility waits to hear from PD. Due to the rural nature of the facility, the youth are typically caught quickly. ● What happens while a child is missing from care? ○ Lynette Overmeyer:

        - Law Enforcement should be looking for the child, but noted that some jurisdictions are so busy they might just run into the kids while doing other work while other jurisdictions are good at following the details of where the child might be and do a more in-depth approach to finding the child.
- What happens upon their return?
    - Lynette:
        - The placement tries to understand what happened.
        - Therapists meet with child immediately (if in QRTP type setting) to understand more information and see how they can support the child not running again.
    - Brandon:
        - Once they're back they process them and try to figure out what happened and what they need moving forward.

- Additional questions from task force members:
    - Stephanie Villafuerte:
        - What is the timeframe when a child is missing when the report is made? Villafuerte noted she has heard that it can vary.
            - Lynette: If from residential, they have to notify right away as a line-of-sight facility. If running from a foster home or group home, because they're allowed to leave placements, sometimes it's not realized that they're missing for hours later.
        - Familiar with volume 7 and debriefing with the youth when they return, is that information stored in the Trails database? If there were subsequent placements for a youth or a new caseworker, would we have a record of the child's history in that regard?
            - Lynette: There's a record in the contact notes, but the caseworker would have to go in and read that. The challenge is that if the caseworker turnover is high, that information can get lost.
        - Anna Cole:
            - Adds that the high-risk victimization tool (HRV) has to be completed upon every run return if the child is in the department's custody. There is a record of that discussion within that

victimization tool within Trails. Lynette agrees and thanks Anna for this addition.

- Beth McNally
    - Question about the training for the HRV tool for caseworkers regarding implementation, accountability for that happening with each run, and what happens if there are concerns for the HRV tool what the process is from there.
        - Lynette outlines issues with the HRV tool.
            - Partly a Trails issue. Trails mod was supposed to roll out in 2017 and only half has done that. To find the tool you have to go into the mod to do a client search and look separately. You cannot access this tool where ongoing and intake workers are working. The two-step process is a challenge.
            - There are no directions for what to do with the tool if they are high risk other than talking to the youth. Caseworkers are good at that, the challenge is that new caseworkers don't get training immediately on the tool. Does not see ongoing training when she looks at the training system.
        - Anna Cole notes this challenge with the HRV tool seems county specific in her experience.
        - Michelle Bradley (Douglas County) provides training twice a year on how to complete the HRV tool.
            - The tool is more information gathering from parents, schools, etc. Once that tool is completed they send it to her, she sends it on and they are reviewed in a monthly meeting. The discussion includes services involved, what might be needed, it might be screened out or

it might go into a further months-long review.
            - If they have custody of the child, they are required to complete the tool but they might not always submit it because it wasn't determined to be high risk.
            - Accountability of completion is a supervisor's responsibility and notes there is follow-up in her department.
        - Beth McNally notes that HRV might be completed on a piece of paper. When it's completed electronically, the tool forces you to answer if the risk is a yes or no and are concerned they answer no even if they don't know for sure.
        - Task Force member Kevin Lash:
            - As a parent of a child that runs, he wasn't aware of this process that's been laid out.
        - Elizabeth Montoya: Her son was in a hospital for 26 hours and there was no information even though DPD had the runaway report. Wondering if that's a fluke.
            - Sgt. Cotter: Has seen this stuff happen. The challenge is that the cops aren't connecting the victim with the name that then gets checked in a database. The systems are not communicating with one another, county to county but also agency to agency.

Additional conversation points:

- Sgt. Cotter talks about the challenge of actually charging someone with harboring a minor.
- The law enforcement system isn't as centralized as human services. Human services has statewide Trails, law enforcement barely has anything like that system. Agency policies and the things they choose to enforce are all dictated by local officials (mayors, council, elected sheriffs, etc). This makes it tough in these meetings, what happens in Denver isn't true statewide as it relates to statewide policies.
    - This is a big topic and the decisions are made at local levels. Is it a frustration? In some ways, but also understands why it's evolved this way. Doesn't believe we should overhaul the entire system, that would have its own challenges. Knows it's not perfect but doesn't know if he'd suggest changing it.

	• Question from task force member: are officers reluctant to get involved? ○ Officers are very generalized and are expected to know about everything and that's not realistic. Very few departments have the resources that Denver or Aurora has. The challenge is that the people investigating or working on runaway cases are also doing murders, burglaries, etc. and they don't necessarily have the right tools. Training is needed. • Dave Lee would like to see additional conversation around Volume 7.
9:25 am	Break
9:30 am	An updated examination of the predictors of running away from foster care in the United States and trends over ten years (2010–2019) • Dr. Tara Richards and Caralin Brascum, researchers from the University of Nebraska Omaha's School of Criminology and Criminal Justice present the results of a national study on youth who went missing from out-of-home placement from 2010 to 2019. The study found that children of color, girls, older youth, children with substance abuse or behavioral issues and those with prior runaway behaviors were all at a higher risk for going missing. • Task force members noted that the information presented is similar to the trends they are familiar with and thanked the presenters for a strong presentation. Questions from the task force: • Kevin Lash wants to understand if there's research around the danger to the community with a runaway. Researchers present did not have data to share. • Dave Lee notes all members have their own anecdotal information but this presentation will help fine-tune the direction of the task force. • Jana Zinser wants to know if the task force can dig into the disproportionate numbers impacting black and brown youth and teen girls. • Becky Miller Updike would like to know if there is more recent data since the mental health crisis that came about from COVID. ○ The presenter notes that the national data is limited and the timeline of relevant data is challenging and unfortunate. • Jenelle Goodrich notes she appreciates the data but says nothing will change unless there is more aggressive legislation and possibly shifting recent legislation that's already passed. The problem is that the authority figures can't do what they need to do because a few

	small stories have changed legislation for the masses. She would like to see a list of protocols of what can and cannot be done (law enforcement, residential, foster care, etc) because running away is not a crime. ○ Believes the only way forward is for the whole system to be shifted. A task force will do only one piece, it needs to be a whole system change.
10:30 am	• Wrap-up • Next Steps
10:45 am	Public Comment Andrew Gabor: Would like to know if there is an effort for a better safety net. What's the safety planning to ensure that the next running event can be prevented in the first place on an individual level? Steve Fisher: Lives across the street from the Tennyson Center since 1995 and has seen hundreds of runs and rescues. From his perspective having read the statutes, he believes there is nothing preventing a fence or a locking of a fence to keep kids safe. Parents and guardians need to be told by facilities the realities of the child's abilities to run away without major intervention or interventions that lead to rash decisions from the youth. Cindy Throop: Believes there are opportunities for short, medium, and long term work. In terms of black children and children of color disproportionately running away, these are also the kids that are disproportionately placed in out-of-home placements. We're a few decades into not having great safety nets for kids. These things could be addressed by better-equipping families of origin.
11:00 am	Closing

Meeting 4 – March 1, 2023

Agenda

Agenda - Timothy Montoya Task Force: Meeting Four

March 1, 2023 | 8am-11am

Virtual - Zoom

Facilitators: Keystone Policy Center

Time	Agenda Topic	Facilitator / Presenter
8:00 am – 8:10 am	• Welcome • Approve minutes for September, November, and January meetings	Stephanie Villafuerte, Chair Beth McNally, Vice Chair
8:10 am – 8:25 am	• Summary of prior meetings • Addition of working group meetings • Overview of today's agenda and goals	Trace Faust, Keystone
8:25 am – 8:40 am	• Defining the term "runaway"	Trace Faust
8:40 am – 9:00 am	• Reporting Requirements: How the law determines the data we collect in Colorado	Stephanie Villafuerte
9:00 am – 9:05 am	**Break**	
9:05 am – 9:50 am	**Data Presentation** • What data is collected? ○ Quantitative v. qualitative • What data is reported? To whom? • How is the data used? • What are the limitations of the data?	Laurie Burney, Provider Performance Manager, Colorado Department of Human Services

	• What data would you like to see from external partners? **Q & A from Task Force**	
9:50 am – 10:15 am	**Breakout Groups** • What does the data presented tell us about the experience of children who run away from placement? • What data is missing for the task force to understand the experience of children who go missing from care?	Full Group Participation
10:15 am – 10:40 am	**Group Debrief**	Keystone
10:40 am – 10:50 am	**Public Comment**	Keystone
10:50 am – 11:00 am	**Closing and Next Steps**	Trace Faust Stephanie Villafuerte

Meeting 4 – March 1, 2023

Materials

2021 Missing Children Annual Report

Colorado Bureau of Investigation

COLORADO
Bureau of Investigation
Department of Public Safety

Missing Children Report

2021 Annual Report

Bringing our Missing Children Home!

Introduction

MISSING CHILDREN AND THE EVOLUTION OF THE PROBLEM

Each year, thousands of children are reported missing in the United States. Colorado is no exception. Although many of those missing children return safely, those who do not continue to be exposed to harmful and dangerous situations. In response to the growing national concern for missing and exploited children, the Federal Children's Assistance Act was passed in 1982. It directed the Federal Bureau of Investigation (FBI) to become actively involved in missing children cases. Federal efforts were further strengthened by the creation of the National Center for Missing and Exploited Children (NCMEC) in 1984.

An average of 39 children are reported missing every 24 hours in Colorado with the majority being runaways.

During this time, child abduction cases were becoming more highly publicized in Colorado and public concern was mounting. In 1985, the legislature created the Colorado Missing Person Clearinghouse. The Clearinghouse serves as a central repository for information on missing children in order to better define the problem. It collects, compiles, exchanges and disseminates information to help find missing children. Today there are Missing Person Clearinghouses in all 50 states as well as the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Canada and the Netherlands. NCMEC continues to work closely with each of the Missing Child Clearinghouses providing training and technical assistance as needed to bring our missing children home.

In 1996, there was public outcry after 9-year-old Amber Hagerman was abducted from a local grocery store in Arlington, Texas while riding her bicycle with her younger brother. Members of the community were outraged there was not a mechanism in place to alert the community when a child goes missing. Thus was born America's Missing Broadcast Emergency Response (AMBER) Alert which is a cooperative effort between law enforcement and the broadcasters to raise awareness in the community when a child is abducted. In 2002, the AMBER Alert program was created in Colorado.

In the 2000s, the definition and reporting guidelines were changed to better protect this vulnerable population. A missing child is defined as any individual less than 18 years of age whose whereabouts are unknown to the child's parents or legal guardian. In 2003, Suzanne's Law increased the age of a missing child from 18 to 21. Additionally, law enforcement is required to enter a missing child into the national criminal justice system within 2 hours of receiving a report for a missing child.

In 2014, federal legislation referred to as "Children Missing from Care" passed requiring state agencies to report a missing child to both the law enforcement agency as well as NCMEC within 24 hours of receiving information about a missing child under their care. This is one of our most at risk populations. Many of the children that fall into this category runaway of their own free will but find themselves in some of the most serious and dangerous situations.

Initially the missing child clearinghouse was established to raise awareness for those children who may have wandered away or who were abducted. Over the decades we have seen these approaches change as our communities change. Today it is less likely that a child will be taken from their bike in their neighborhood and more likely they will fall victim through online enticement which can occur through various social media apps and online gaming. This is the new way predators are abducting our children. It is happening less on the streets in our communities and more often in our homes and through our electronic devices. These predators are just as dangerous to our children.

We must continue to evolve with the times and do what we can to protect our most vulnerable population.

STATE CLEARINGHOUSE ACTIVITIES

- Develop and present specialized training programs to criminal justice and youth service professionals.
- Provide information regarding cases originating in Colorado to the NCMEC for inclusion in the national directory of missing and abducted children.
- Provide and ensure follow-up on all missing children cases originating in other states but linked to Colorado in some way, when requested.
- Provide information to out-of-state agencies concerning applicable Colorado State laws, relevant agency relationships, and recovery procedures.
- Help reunite missing children with their lawful parent or guardian by establishing cooperative mechanisms with other state clearinghouses.
- Assist in the preparation of missing children bulletins and their distribution to law enforcement agencies and school districts.
- Counsel citizens and business groups on how they may respond to the plight of missing children.
- Attempt to locate abductors by completing nationwide automated record and file searches and interacting with other organizations, agencies, or groups that may be instrumental in locating missing children.

RESPONSIBILITIES

LISTS

The Colorado Bureau of Investigation (CBI) Missing Persons Unit, compiles and distributes lists of missing children from reports submitted by local law enforcement agencies. The reports are released to school districts and to any other person or organization the Unit determines may be instrumental in the identification and recovery of missing children.

STATISTICS

Consistent with statute, the Missing Persons Unit maintains and distributes statistics on missing children which include:

- The number of missing children reported.
- The number of missing children cases resolved.
- The approximate physical location at which each child was last seen.
- The time of day each child was last seen.
- The age, gender, and physical description of each child reported missing.
- The activity the child was engaged in at the time last seen.
- The number of reported sightings of missing children.

(See charts on pages 6-10)

This report documents the circumstances of recovery of missing children. These include a breakdown by age, race, and sex in cases resolved by: recovery by a law enforcement agency, recovery by an agency other than law enforcement, voluntarily returned, deceased, and circumstances unknown. These were summarized for the first time in the 1991 Annual Report to give a clearer picture of what is being done to resolve missing children cases in Colorado.

DEFINITIONS

CCIC - Colorado Crime Information Center

Kidnapped - A person who is missing under circumstances indicating that the disappearance is not voluntary and who has been abducted by a stranger or non-family member.

Lost - A person who is presumed to have wandered away and has become lost and unable to return to a known location.

Missing Child - A child whose whereabouts are unknown, whose domicile at the time he was first reported missing was Colorado, and whose age at the time he was reported missing was seventeen years or younger.

NCIC - National Crime Information Center

NCMEC - The National Center for Missing and Exploited Children

Non-Custodial Abduction - The taking of a child by the non-custodial parent or family member, with the intent to deprive the legal parent or guardian possession of that child.

Runaway - An un-emancipated juvenile who has left the home environment without a parent's or legal guardian's permission. (Classified as non-suspicious for statistical purposes.)

Resources

NCMEC

The National Center for Missing and Exploited Children's (NCMEC) mission is to help prevent child abduction and sexual exploitation; help find missing children; and assist victims of child abduction and sexual exploitation, their families, and the professionals who serve them.

NamUs

The National Missing and Unidentified Persons System (NamUs) is a national centralized repository and resource center for missing persons and unidentified decedent records. NamUs is a free online system that can be searched by medical examiners, coroners, law enforcement officials and the general public from all over the country in hopes of resolving these cases.

Rocky Mountain Innocence Lost Task Force

Part of a joint initiative with the Department of Justice that targets organizations involved in child prostitution.

MONITORING

The Unit reviews missing person's reports submitted to the Colorado Crime Information Center (CCIC) and the National Crime Information Center (NCIC) for validity, completeness and accuracy and ensures the originating agency makes any necessary corrections or additions.

When a child has been missing for thirty days, the Unit must attempt to obtain the child's dental records and attach them to the NCIC missing person report.

The Unit sends lists of children missing from Colorado to each Colorado school district for comparison with their enrollment records to identify missing children in their schools. If a district chooses, it may submit enrollment lists to the Unit for comparison with NCIC records to locate children missing from all states. When a match is verified, the Unit notifies the appropriate authorities to facilitate the return of the missing child.

AMBER ALERTS

AMBER

America's Missing Broadcast Emergency Response

The AMBER Alert System started in Dallas-Fort Worth in 1996 after 9-year-old Amber Hagerman was kidnapped while riding her bicycle in Arlington, Texas. Amber was later found brutally murdered, her case remains unsolved to this day. Broadcasters and law enforcement worked together to develop an early warning system to help find abducted children. America's Missing Broadcast Emergency Response was born, with the acronym AMBER in dedication to Amber Hagerman. Colorado adopted the AMBER alert program in 2002.

AMBER alerts enable communication with the pubic to disseminate information quickly for an abducted child. The Department of Justice created a criteria to release AMBER alerts to the public.

The criteria for AMBER alerts consists of the following:

- The abducted child must be 17 years of age or younger.
- The abducted child must be in immediate danger of serious bodily harm or death.
- There must be enough descriptive information available to believe a broadcast will assist or aid in the recovery of the child.
- The activation must be requested by a local law enforcement agency or AMBER Designee from another state.

The Colorado Bureau of Investigation is the liaison between local law enforcement and the primary Emergency Alert System (EAS) broadcaster for issuing alerts. AMBER alerts can only be issued by the Colorado Bureau of Investigation in the state of Colorado. In order to notify the public quickly of an AMBER alert, notification outlets include: statewide media, highway signboards, emergency alert system, wireless emergency alerts, Twitter, and other outlets such as social media and lottery machines. If the circumstances of the missing child does not meet AMBER criteria, a Missing Endangered Advisory Alert can still be sent out to the media, although it will not be sent through the Emergency Alert System or as a Wireless Emergency Alert.

AMBER Statistics*

- 395 attempted abductions occurred in 2021
- 1,114 children recovered specifically because of the AMBER Alert
- 123 children recovered specifically because of WEA (wireless emergency alerts)

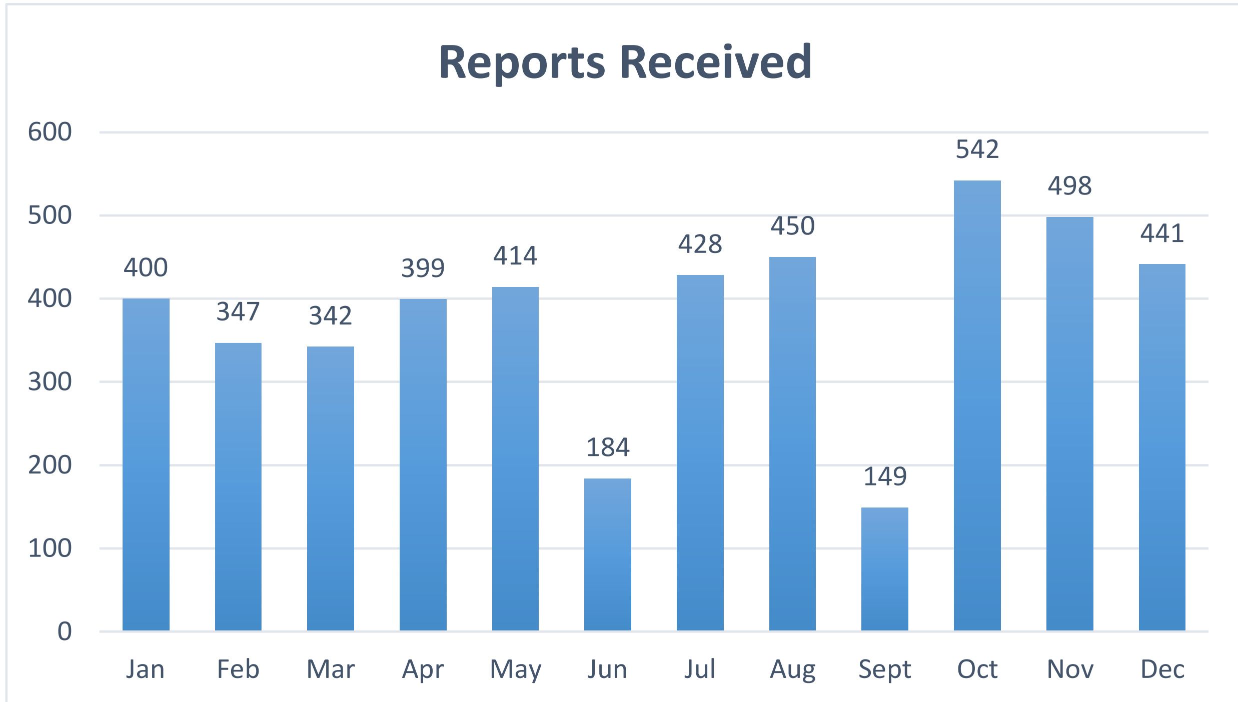
Colorado AMBER Alerts

- In 2021, there were 5 AMBER Alerts issued
- Every child in the AMBER Alerts were recovered safely
- The number of AMBER Alerts decreased by one from 2020

* As of May 2022 stats from US Dept of Justice http://amberalert.ojp.gov/statistics

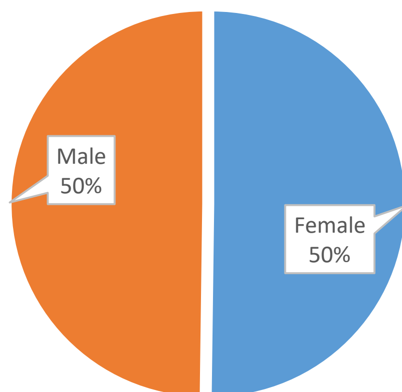
FACTS OF INTEREST

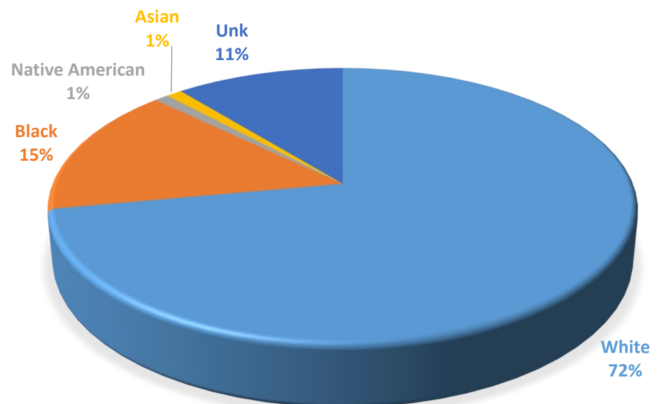
Information in this report was provided to the Colorado Bureau of Investigation (CBI) by local law enforcement agencies using the CCIC automated information system. Each report filed with the local agency is entered into the CCIC computer as a separate case. The numbers below reflect cases as opposed to actual missing children, i.e. some children may have been reported missing, recovered, and subsequently missing once more. Thus, the intent of this report is to reflect the total number of entries in CCIC and total number of entries removed from CCIC in a given month. It does not indicate recovery rates based on each child. Finally, because this data is based only on reports, the program has no way of identifying those children who have not been reported to local authorities by parents or legal guardians. This information reflects persons reported as missing who are age 17 and younger.



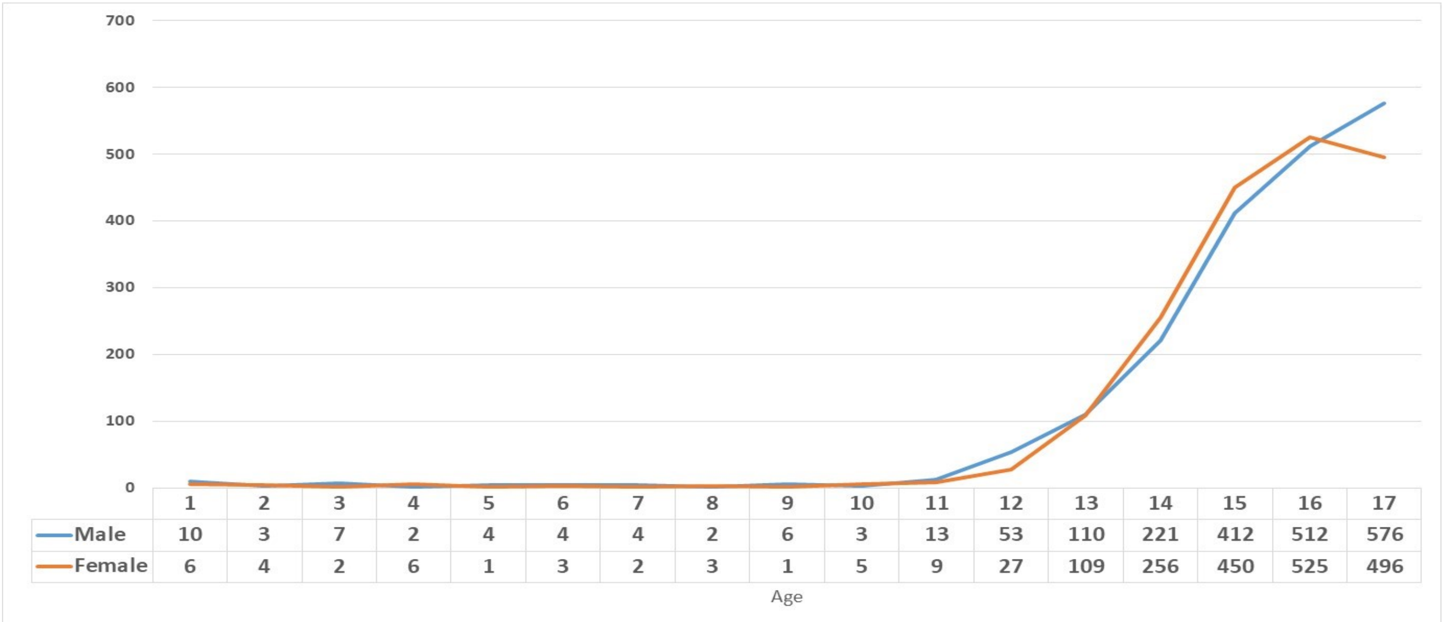
A total of 4,594 reports were received in 2021.

This is a decrease of 56.04% from the 8,197 reports received in 2018.





Missing by Age and Sex



81% of the children reported as missing were between the ages of 14 and 17.

45% of the children reported as missing were between the ages of 15 and 16.

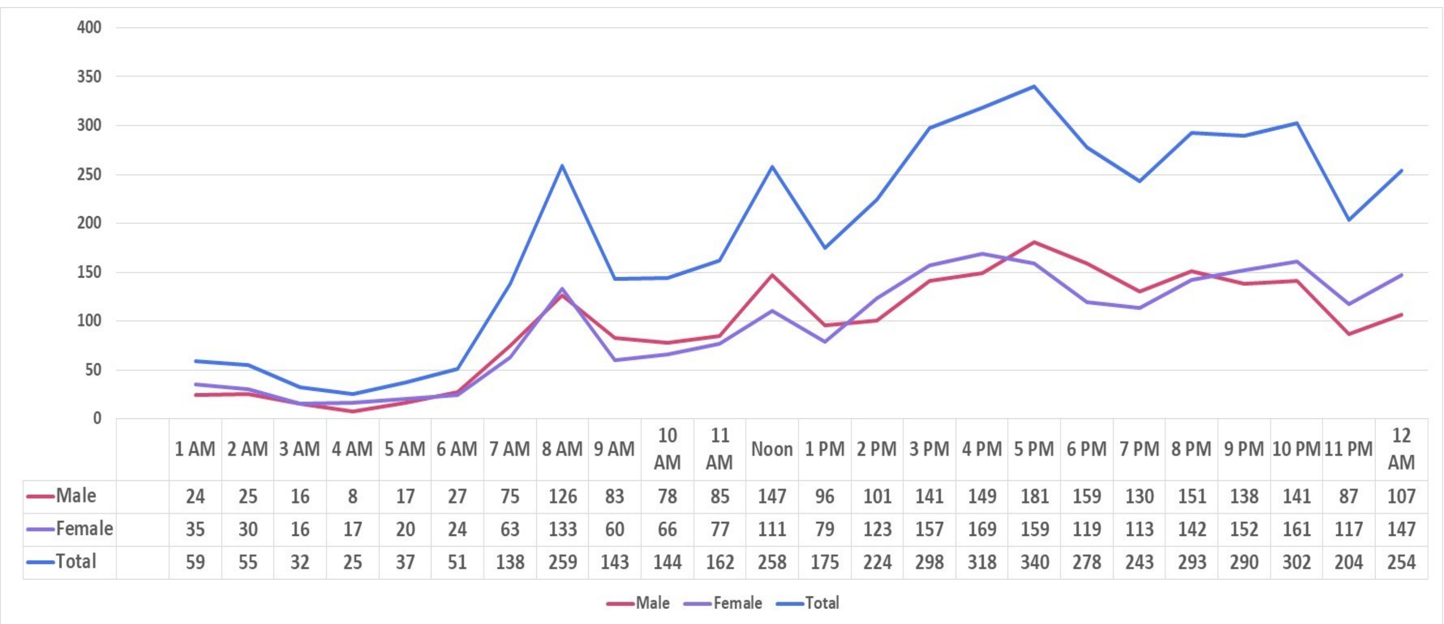
The highest reported day of the week for children to last be seen was Friday.

The most common time for children to be last be seen was around 5 PM.

Day Last Seen

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
Female	284	362	335	312	311	395	250	2305
Male	321	340	320	351	322	385	303	2286
Total	605	702	655	663	633	780	553	4591

Time Last Seen



CIRCUMSTANCE OF MISSING

Non-Suspicious - typically signifies children who have either run away or have been taken by a family member but are not considered to be a victim of a non-custodial abduction

Lost - a person who is presumed to have wandered away and has become lost and unable to return to a known location

Kidnapped - a person who is missing under circumstances indicating that the disappearance is not voluntary and who has been abducted by a stranger or non-family member

Non-Custodial Abduction - the taking of a child by the non-custodial parent or family member with the intent to deprive the legal parent or guardian possession of that child

Suspicious - a person who is missing with insufficient information to enable placing the record in any other probable category

Unknown - the circumstances of their missing were not reported to law enforcement or the CBI

Age	Non-suspicious	Lost	Kidnapped	Non-custodial kidnap	Suspicious circumstance	Unknown	Total
0	13	0	0	2	0	0	15
1	2	0	1	3	3	0	9
2	8	0	0	0	0	1	9
3	1	0	0	2	1	1	5
4	4	0	0	2	2	0	8
5	3	0	0	0	1	1	5
6	4	0	0	2	2	0	8
7	2	0	0	0	0	2	4
8	6	0	0	0	1	0	7
9	6	0	0	0	0	2	8
10	19	0	0	1	1	1	22
11	75	0	0	0	4	1	80
12	216	0	1	0	1	1	219
13	469	2	0	1	3	2	477
14	848	1	0	1	3	8	861
15	1018	1	1	1	6	11	1038
16	1049	1	0	0	10	12	1072
17	728	1	0	2	3	13	747
TOTAL	4471	6	3	17	41	56	4594

Activities When Missing

	Female	Male	Total
At Friends/Relatives Inside Residence	64	53	117
At Friends/Relatives Outside Residence	31	20	51
At Home Inside Residence	1,254	1,187	2,441
At Home Outside Residence	301	275	576
At Public Place Inside Building	15	27	42
At Public Place Outside	45	77	122
Friends/Relatives Residence In Vehicle	17	4	21
Friends/Relatives Residence On Foot	14	16	30
In Custody Of A Public Institution	24	62	86
Inside A Building	16	17	33
Inside Private Residence	83	87	170
Inside Public Place	11	13	24
Inside School Building	71	59	130
On Trip In Local Area	0	2	2
On Vacation Trip In State	0	1	1
On Vacation Trip Out-Of-State	0	0	0
Other	20	40	60
Outside A Building	16	12	28
Outside At Private Residence	33	24	57
Outside At Public Place	29	30	59
Outside School Building	69	73	142
Public Place In Vehicle	12	11	23
Public Place On Foot	33	39	72
School In Vehicle	4	3	7
School On Foot	8	12	20
Traveling To Or From Anywhere On A Bicycle	5	3	8
Unknown	126	133	259
Work In Vehicle	2	2	4
Work On Foot	5	2	7
Total	**2,308**	**2,284**	**4,594**

Over half of the children were reported to have been last seen in or near their residence. A residence can be a family home, non-profit residential group home, foster home, or residential treatment facility.

CIRCUMSTANCES OF RECOVERY

Blank / Unknown - the circumstances of the child's recovery was not reported to law enforcement or the CBI

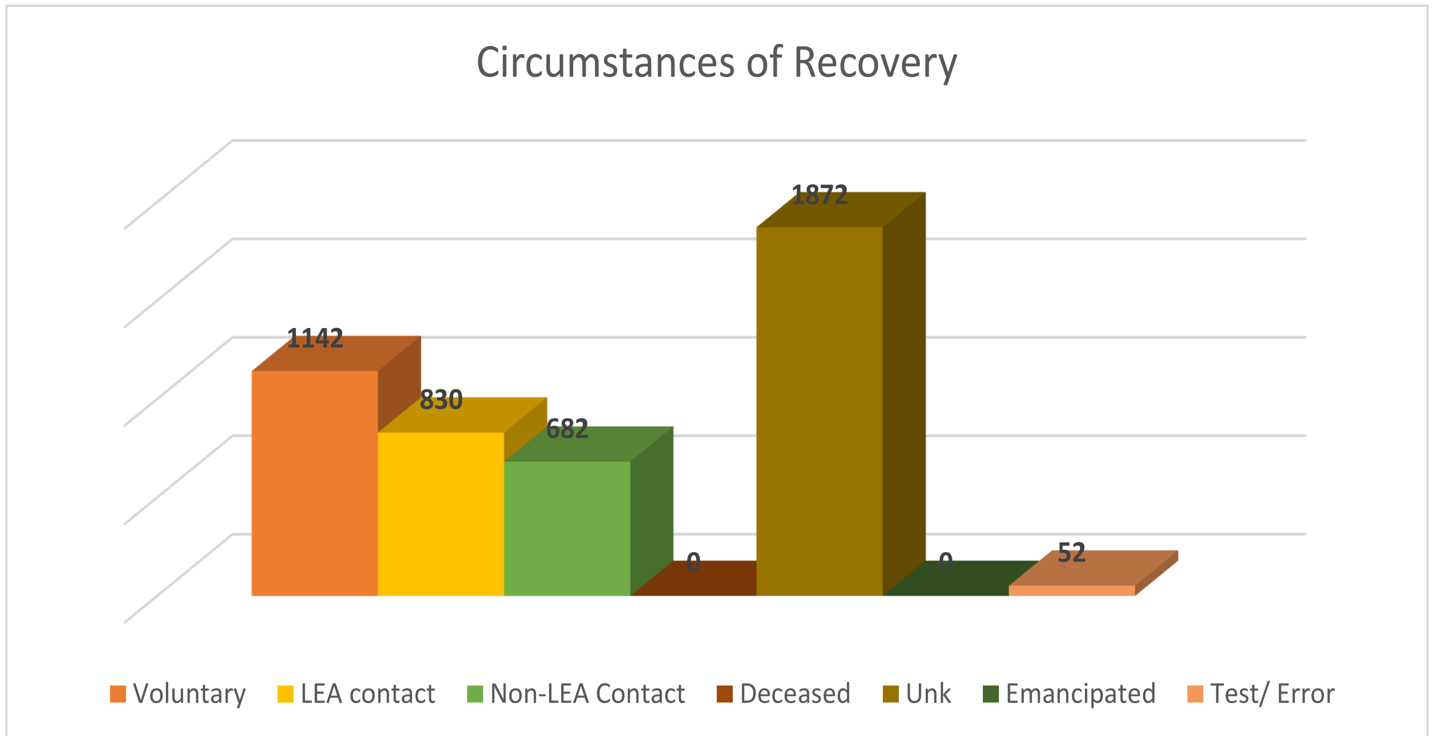
Deceased - the child was located deceased

Contacted by Law Enforcement - contact with law enforcement was responsible for the recovery of the child

Non-Law Enforcement Agency Contact - contact with a non-law enforcement agency was responsible for the recovery of the child

Test Record - the record was entered as a test record or was entered in error

Voluntary - the child returned voluntarily



Of the cases closed in 2021, 25% were resolved when the child retuned voluntarily.

Contact with Law Enforcement was responsible for the resolution of another 18% of cases. The remaining circumstances of recovery are from a non—law enforcement agency or the circumstances of the child's recovery are not reported to law enforcement or the CBI.

MISSING CHILDREN'S DAY POSTER CONTEST

Since 1983, May 25 has been designated as National Missing Children's Day and every year the United States Department of Justice (DOJ) takes time to commemorate the valiant and unselfish acts of the many organizations and individuals who bring our missing children home.

In conjunction with this event the DOJ sponsors a national poster contest for fifth graders and announces the winner at the annual National Missing Children's Day Ceremony in Washington, DC. Each state submits one entry for the national contest.

Kacey from Cheraw Elementary was the winner for the 2021 Colorado contest and her poster is featured on the cover of this report. The second and third place winners are shown below.

2nd Place

Aliana

Holly School

3rd Place

Collins

Holly School

To learn more about the National Missing Children's Day Poster Contest or to see previous submissions, please visit https://ncjtc.fvtc.edu/programs/PR00005772/37th-annual-national-missing-childrens-day

Meeting 4 – March 1, 2023

Materials

Responding to Youth Missing from Foster Care

Children's Bureau

Responding to Youth Missing From Foster Care

To find statute information for a particular State, go to State Statutes Search.

As of September 30, 2018, an estimated 4,247 youth in foster care were reported to be on runaway status.[1] Research shows that most youth are gone for only a week or less when they run away, but many are gone for a month or more. The reasons that youth run away from their placement vary, but some common themes include needing to have contact and maintain connectedness with families or friends, feeling unsafe or uncared for in their placement, or wanting more freedom and autonomy than the placement can offer them. While absent from care, youth are at high risk of being sexually or physically victimized, engaging in delinquent behavior, using drugs or alcohol, or being the victims of human trafficking.[2]

WHAT'S INSIDE

- Protocols for reporting children missing from care to law enforcement
- Protocols for locating children missing from care
- Determining the factors that led to a child's absence from care
- Determining the suitability of current and subsequent placements
- Assessing the child's experiences while absent from care
- Timeframes for closing a child's placement after running away

[1] Children's Bureau. (2019). *The AFCARS report: Preliminary FY 2018 estimates as of August 22, 2019 (No. 26)*. U.S. Department of Health and Human Services, Administration for Children and Families.
[2] Courtney, M., Skyles, A., Miranda, G., Zinn, A., Howard, E., & Goerge, R. (2005). *Youth who run away from out-of-home care*. Issue brief #103. Chapin Hall Center for Children, University of Chicago.

Child Welfare Information Gateway

Children's Bureau
An Office of the Administration for Children & Families

Title IV-E (42 U.S.C. § 671(35)) requires States
Title IV-E (42 U.S.C. § 671(35)) requires States
to develop and implement specific protocols for locating and ensuring the safety of youth who are missing from care, including all the following:

- Expeditiously locating any youth missing from foster care
- Determining the primary factors that contributed to the youth's running away or otherwise being absent from care
- To the extent possible and appropriate, responding to those factors in current and subsequent placements
- Determining the youth's experiences while absent from care, including screening the youth to determine if the youth is a possible sex trafficking victim
- Reporting to law enforcement authorities immediately, and in no case later than 24 hours, after receiving information on a missing or abducted youth for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation and to the National Center for Missing and Exploited Children (NCMEC)

For this publication, State laws and policies regarding the actions that State child welfare agencies must take when a child or youth for whom they have responsibility has gone missing from an out-of-home placement were collected from all States and the District of Columbia.[3] An analysis of the information collected informs the content that follows.

PROTOCOLS FOR REPORTING CHILDREN MISSING FROM CARE TO LAW ENFORCEMENT

When a social services agency receives a report that a youth in out-of-home care is missing, the laws and policies in approximately 44 States[4] and the District of Columbia require that the agency or agency representative file a missing-persons report with the local law enforcement agency immediately and in no case later than 24 hours after receiving the information. The report must include a request that the youth's information be uploaded to the NCIC database of missing persons.

If the youth's location is not immediately determined, the agency caseworker also must file a report with NCMEC within 24 hours. NCMEC accepts reports from across the country and provides agencies with assistance in locating and returning to safety youth who have gone missing from care.[5] When making the report to NCMEC, the caseworker should be prepared to provide the following information about the youth and the youth's case:

- The youth's name and date of birth
- A physical description of the youth, including a description of the clothing worn at the time the youth was last seen, hair and eye color, height, weight, complexion, eyeglasses or contact lenses, braces, body piercings, tattoos and/or other unique physical characteristics

[3] Laws and policies regarding these issues were not found in the databases and publicly available websites for Alabama, Delaware, Hawaii, Ohio, Pennsylvania, South Dakota, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

[4] The word "approximately" is used to stress the fact that States frequently amend their laws. This information is current only through May 2020. States that have developed protocols for making reports of youth missing from care include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

[5] For more information on the services provided by NCMEC, see the factsheet *Children Missing From Care*.

- A photo of the youth
- The name and contact information of the youth's primary caseworker and supervisor
- The investigating law enforcement agency name, contact information, and case number (i.e., missing-persons report number)
- Contact information of the youth, including information about cell phone numbers, email addresses, social networking contacts, aliases, and nicknames
- The circumstances of the missing youth's disappearance, including the date the youth went missing or was last seen
- Suggested location, people, or direction where the youth could be located, including parents and relatives
- Any other factual, biographical, or historical information, including any health or behavioral health concerns, that may assist with locating the missing youth

PROTOCOLS FOR LOCATING CHILDREN MISSING FROM CARE

In addition to making the required reports to law enforcement and NCMEC, caseworkers are required to notify other persons when a youth is missing from care. This may include the youth's parents, guardian, or other relatives; the youth's attorney or guardian ad litem; the caseworker's supervisor; the court with jurisdiction over the case or the attorney general; and the youth's Tribe (if applicable). The caseworker also must maintain regular contact with law enforcement and NCMEC for updates on progress locating the youth.

In addition, 33 States[6] and the District of Columbia require caseworkers to engage in other actions to locate the youth. These efforts may include, but are not limited to, contacting the following entities or individuals:

- Relatives, including the youth's parents and siblings
- Neighbors and landlord of the youth's last known address
- Teachers, counselors, and other personnel from the school that the youth last attended or other schools the youth attended, if there is knowledge that the youth had a close relationship with persons at that school
- Past known caregivers who have cared for the youth or any other caregivers with whom the youth is known to have had a close relationship
- Probation or parole officer, if applicable
- Juvenile and adult detention centers, if applicable
- Local emergency shelters, local hospitals, and homeless youth programs
- The youth's employer, if applicable

Other search efforts may include the following:

- Searching the youth's belongings
- Calling or texting the youth's cell phone
- Checking the youth's computer, social media accounts, or other online accounts

[6] Arizona, Arkansas, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin

- Contacting the youth's friends, relatives, or known associates
- Searching areas that the youth is known to frequent
- Interviewing other youths at the youth's placement to determine if the youth shared his or her plans or contact information for other friends

DETERMINING THE FACTORS THAT LED TO A CHILD'S ABSENCE FROM CARE

In 40 States[7] and the District of Columbia, caseworkers are required to engage the youth in conversation to determine why the youth ran away from his or her placement. Some questions that need to be addressed may include the following:

- What led the youth to leave his or her placement?
- Did the placement address the youth's needs? Why or why not?
- Was there an incident that caused the youth to leave the previous placement?

Studies involving interviews with youth who ran away from foster families and the adults who care for or work with them suggest that the reasons youth run away from out-of-home care are varied. The most common reasons include wanting to regain control over their lives or express their feelings, a desire to maintain relationships with family or friends, and as a response to having been victimized or feeling unsafe in their placement.[8]

DETERMINING THE SUITABILITY OF CURRENT AND SUBSEQUENT PLACEMENTS

In 36 States[9] and the District of Columbia, the youth's caseworker must, to the extent possible, address the factors that contributed to the youth's running away from the current placement or may contribute to them running away from subsequent placements. Some of the determinations to be made include the following:

- The appropriateness of the youth returning to the same out-of-home placement
- Whether a new or previous placement is in the youth's best interests
- What immediate needs the youth and/or placement provider may have and what immediate steps need to be taken to better support both the youth and placement provider
- How to best meet the youth's needs, both short term and long term, so that the youth feels safe, cared for, and comfortable remaining in the placement

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[7] Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming

[8] Dworsky, A, Wulczyn, F., & Huang, L. (2018). Predictors of running away from out-of-home care: Does county context matter? *Cityscape: A Journal of Policy Development and Research*, 20(3), 101–115.

[9] Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin

ASSESSING THE CHILD'S EXPERIENCES WHILE ABSENT FROM CARE

When a youth returns to care, the caseworker must immediately ensure that law enforcement and NCMEC have been notified so efforts to locate the youth can be suspended. In addition, parents or guardians and all other persons who were involved in the search must be notified within 24 hours. In 39 States,[10] caseworkers must interview the youth about his or her experiences while missing from care. Topics of conversation may include discussing with whom the youth lived while absent from care, how the youth took care of him- or herself, and whether the youth suffered any harm. In 39 States,[11] the caseworker also must screen the youth to determine whether he or she was a victim or at risk of being a victim of sex trafficking or online enticement.

In 14 States,[12] if it is determined that the youth is a victim of sex trafficking, the caseworker must make a report to child protective services and provide or coordinate provision of services to the youth.[13] In 20 States,[14] the caseworker must report the determination of sex trafficking to law enforcement.

TIMEFRAMES FOR CLOSING A CHILD'S PLACEMENT AFTER RUNNING AWAY

According to Federal guidance, when a title IV-E-eligible youth is temporarily absent from a foster home, whether because the youth has run away or as a result of other circumstances (e.g., the youth is on a weekend home visit or is hospitalized for medical treatment), the title IV-E agency may provide a full month's title IV-E foster care maintenance payment to the licensed provider. This is only if the brief absence does not exceed 14 days and the child returns to the same provider.[15] Policies in 13 States provide timelines for continuing foster care payments, ranging from immediate cessation of payments (in Mississippi) to up to 30 days (in Maryland).[16] In six States,[17] payments to the foster care provider will cease immediately upon determination that the youth will not return to the placement.

Policies in 15 States[18] provide guidance on when an agency can petition the court to dismiss the dependency case (i.e., to be relieved of custody) of a youth who has not returned to care. In general, the dependency case cannot be dismissed until the youth has been missing for 6 to 12 months

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[10] Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin

[11] Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming

[12] Alaska, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Missouri, Nebraska, New Mexico, North Dakota, Rhode Island, Vermont, West Virginia, and Wyoming

[13] For more information, see the Child Welfare Information Gateway publication *Responding to Child Victims of Human Trafficking*.

[14] Arizona, Arkansas, Georgia, Idaho, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, and Virginia

[15] See the Information Memorandum ACYF-CB/FYSB-IM14-1 that was issued November 4, 2014 by the U.S. Department of Health and Human Services, Administration for Children and Families.

[16] Foster care payments will continue for 24 hours in Georgia; 5 days in Alaska and Indiana; 7 days in New York, Oklahoma, and Oregon; 10 days in New Hampshire and Utah; 14 days in Iowa (may be extended to 30 days); 15 days in Louisiana and Vermont; and 30 days in Maryland.

[17] Alaska, Indiana, New Hampshire, Oklahoma, Oregon, and Vermont

[18] Arizona, Louisiana, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, Oklahoma, Oregon, South Carolina, Utah, Washington, West Virginia, and Wisconsin

or while the youth is still a minor. A court also will determine if the agency has made diligent efforts to locate the youth and whether the youth has safety concerns or service needs.

This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures.

SUGGESTED CITATION:

Child Welfare Information Gateway. (2020). *Responding to youth missing from foster care.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau

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Meeting 4 – March 1, 2023

Materials

State Approaches to Children Missing from Foster Care

U.S. Department of Health & Human Services

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL SNAPSHOT OF STATE AGENCY APPROACHES TO REPORTING AND LOCATING CHILDREN MISSING FROM FOSTER CARE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Inspector General

May 2022
A-07-20-06095

Office of Inspector General

https://oig.hhs.gov/

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: May 2022
Report No. A-07-20-06095

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

National Snapshot of State Agency Approaches To Reporting and Locating Children Missing From Foster Care

Why OIG Did This Audit

Federal law requires States to provide safe and stable out-of-home care for children in foster care until they are safely returned home, placed permanently with adoptive families, or placed in other planned, permanent living arrangements. Concerns regarding States' lack of knowledge regarding the whereabouts of children who go missing from foster care (missing children) have garnered national media attention. This report provides decisionmakers with a national snapshot of the number of missing children as well as the State-level approaches for reporting on and locating these children.

Our objectives were to: (1) summarize nationwide data on missing children, (2) examine the policies and procedures adopted by State agencies to report and locate missing children, (3) identify any barriers and other deficiencies in the State agencies' policies and procedures related to missing children, and (4) report on the challenges that the State agencies identified with respect to reporting and locating missing children.

How OIG Did This Audit

We based our findings on responses to a questionnaire and followup interviews we conducted with State agencies. The questionnaire and interviews focused on collecting data for all children in foster care placements who went missing at any time from July 1, 2018, through December 31, 2020 (audit period).

What OIG Found

There were 110,446 missing children episodes during our audit period. State agencies' data showed the following: the percentages of missing children by State ranged from 0 to 7 percent; the average number of days that the children were missing ranged from 7 to 96 days; the number of children who were still missing as of December 31, 2020, was 6,619; the average number of times children went missing ranged from 1 to 7 times; and the majority (65 percent) of missing children were 15 to 17 years old. The data also showed that among the missing children, 51 percent were females, 48 percent were males, and 1 percent were reported without gender data, or reported as transgender or undecided.

With respect to our second objective, all 50 State agencies said that they had implemented policies and procedures regarding measures to report and locate missing children. Some State agencies reported enhanced procedures when a high-risk child went missing, or created special units or had specifically designated staff to help locate missing children.

With respect to our third objective, we identified several barriers and other deficiencies in State agencies' policies and procedures. These barriers included limitations in State agencies' data systems, lack of oversight to ensure timeliness when reporting missing children, and issues involving the collaboration and exchange of information with Federal agencies and law enforcement.

With respect to our fourth objective, the most frequently identified challenges were: locating children who repeatedly go missing from foster care; obtaining cooperation from missing children's families and friends and from law enforcement; finding correct placements for children to prevent them from running away; and a lack of awareness of the support and technical assistance that the Department of Health and Human Services, Administration for Children and Families (ACF) provides.

What OIG Recommends

This report makes no recommendations. However, we expect that ACF will use the information in this report as it works with State agencies to improve outcomes for missing children and reduce the number of missing children episodes. ACF elected not to provide formal written comments on our draft report but did provide technical comments, which we addressed as appropriate.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/72006095.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Federal foster care program, authorized by Title IV-E of the Social Security Act (the Act), as amended, helps States provide safe and stable out-of-home care for children who meet certain eligibility requirements until they are safely returned home, placed permanently with adoptive families, or placed in other planned, permanent living arrangements. Concerns regarding States' lack of knowledge regarding the whereabouts of children who go missing from foster care have garnered national media attention.[1]

As part of our oversight activities, we are conducting a series of audits related to children missing from foster care (who this report refers to as "missing children"). This report provides Federal, State, and local decisionmakers with a national snapshot of the number of missing children as well as the State-level approaches to reporting on and locating these children.[2] The data summarized in this report will provide insight into the issues surrounding missing children and share approaches for addressing those issues in order to reduce the number of, and improve outcomes for, episodes in which children go missing from foster care (missing children episodes).[3]

OBJECTIVES

The objectives of our audit were to: (1) summarize nationwide data on missing children, (2) examine the policies and procedures adopted by State agencies to report and locate missing children, (3) identify any barriers and other deficiencies in the State agencies' policies and procedures related to missing children, and (4) report on the challenges that the State agencies identified with respect to reporting and locating missing children.

[1] The Washington Post, "The other missing children scandal: Thousands of lost American foster kids." Available online at https://www.washingtonpost.com/news/posteverything/wp/2018/06/18/the-other-missing-children-scandal-thousands-of-lost-american-foster-kids/ (accessed on Jan. 25, 2022).

[2] We are also conducting audits to determine whether States are reporting missing children to law enforcement authorities for entry into the National Crime Information Center's (NCIC's) Missing Persons File and reporting missing children to the National Center for Missing and Exploited Children (NCMEC) as required.

[3] In the context of this report, an "episode" refers to a single instance in which a child who has been placed in foster care goes missing, and the child's State of residence updates that child's status to "missing" in its data and reporting systems.

BACKGROUND

Federal and State Foster Care Programs

Within the Department of Health and Human Services, the Children's Bureau, a program office within the Administration for Children and Families (ACF), is responsible for administering the Title IV-E program. The Children's Bureau issues program instructions outlining the information that States must report to receive Federal funding. In addition, the Children's Bureau monitors State child welfare services through various assessment reviews and uses the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) to collect information from the States on all children in foster care.[4]

The Federal foster care program is an annually appropriated program that provides funding to States for the daily care and supervision of children who meet eligibility requirements. Funding is awarded by formula as an open-ended entitlement grant and is contingent upon an approved State plan to administer the program. Each State must therefore submit to ACF for approval a State plan that designates a State agency that will administer the program for that State (the Act § 471(a)(2)). The State agency must submit yearly estimates of program expenditures as well as quarterly reports of estimated and actual program expenditures in support of the awarded funds.

The State plan designates a State authority or authorities responsible for establishing and maintaining standards for foster family homes and child care institutions, including standards related to safety, and requires that the State apply the standards to any foster family home or child care institution receiving Title IV-E or Title IV-B funds (the Act § 471(a)(10)).[5] The State plan must also ensure that financial assistance is made available for eligible children and that the State has developed and implemented standards to ensure that children in foster care placements receive quality services that protect their health and safety (the Act § 471(a)(22)).

For many decades, State-level responsibility for the safety and well-being of a child in foster care ended at the age of 18 (or 19, at the State's discretion). In 2008, the Fostering Connections to Success and Increasing Adoptions Act amended Title IV-E of the Act by giving States the option to extend the age of eligibility for federally funded foster care to 21.[6] In doing so, the Federal Government provided States with a financial incentive to allow young people to remain in foster care until the age of 21 (extended foster care). These 18- to 21-year-olds must

[4] AFCARS is a data collection system that was created to make available national information on children in foster care and their families. The Children's Bureau uses AFCARS data for multiple reasons, including assessing outcomes for children and trend analysis. NCANDS is a voluntary data collection system that gathers information from all 50 States about reports of child abuse and neglect.

[5] Title IV-B of the Act authorizes grants to States and Tribes for child and family services.

[6] The Fostering Connections to Success and Increasing Adoptions Act of 2008, P.L. No. 110-351 (Oct. 7, 2008).

also participate in education, work, or work-related activities, or have a documented medical condition that prohibits such participation (the Act § 475(8)(B)).

Most State agencies directly administer their foster care programs. As of the time of our audit work, though, nine States had structured their foster care programs such that overall administration is executed at the county level. Programs in two other States are partially administered at the county level. For this report, we refer to both variations of these structures as "State-supervised, county-operated programs."

Missing Children

Missing children are those who run away or otherwise are missing from foster care placements and who are not in the physical custody of the agency, individual, or institution with whom the child has been placed; a missing child's actual whereabouts may be known or unknown.[7] These children who go missing from their approved placements are at higher risk of experiencing harm, substance use, and trafficking.[8] In recognition of the vulnerability associated with missing children, the Preventing Sex Trafficking and Strengthening Families Act (Strengthening Families Act) amended the Act and added requirements governing how State agencies respond when children are missing from foster care.[9]

In addition to being required to report missing and abducted children to law enforcement and to the National Center for Missing and Exploited Children (NCMEC), State agencies must develop policies to quickly locate children who run away from foster care or who otherwise go missing (the Act §§ 471(a)(35)(A) and (B)). NCMEC is a nonprofit organization funded by a grant from the Department of Justice that serves as a reporting center for issues related to the prevention of and recovery from child victimization. NCMEC operates a 24-hour, toll-free hotline so that individuals may report information regarding any missing child. NCMEC also provides technical assistance in identifying, locating, and recovering victims of child sex trafficking.[10]

The Missing Children Act of 1982 directed the U.S. Attorney General to keep records on all missing children in the National Crime Information Center's (NCIC's) Missing Persons File, which

[7] This definition is drawn from the Child Welfare League of America. See its website at https://www.cwla.org/how-should-agencies-respond/ (accessed on Jan. 25, 2022).

[8] See for example, "Examining the Link: Foster Care Runaway Episodes and Human Trafficking," a research brief accessible at https://www.acf.hhs.gov/sites/default/files/documents/opre/foster_care_runaway_human_trafficking_october_2020_508.pdf (accessed on Jan. 25, 2022).

[9] The Preventing Sex Trafficking and Strengthening Families Act, P.L. No. 113-183 (Sept. 29, 2014). Although tied to the receipt of Federal foster care funding, the requirements apply to all children regardless of their eligibility for Title IV-E payments.

[10] We have an ongoing audit of the State agencies' reporting of missing children to NCMEC and plan to issue a separate report on the results of this work.

is maintained by the Federal Bureau of Investigation (FBI), and to disseminate those records to State and local agencies.[11]

Law enforcement agencies submitting information on missing children to NCIC are required to also notify NCMEC of each report that relates to a child who has been reported as missing from foster care, and to maintain close liaison with NCMEC and child welfare agencies in order to exchange information and technical assistance about missing children cases (34 U.S.C. § 41308).

Although there is no database interface between NCMEC and NCIC, NCMEC is permitted to search the NCIC's Missing Persons File to assist with locating missing children who are between the ages of 18 and 21.

A missing child episode takes on even greater urgency when the child's safety is considered to be at high risk. Although the precise definition of this term varies by State, States generally define a "high-risk child" as having one or more of the following attributes: (1) 12 years old or younger, (2) a history of runaway episodes or sexual exploitation, (3) one or more diagnosed medical conditions, and (4) high emotional or psychiatric sensitivity.

HOW WE CONDUCTED THIS AUDIT

The information in this report is based on responses to a questionnaire completed by State agency program administrators in all 50 States. We distributed the questionnaire, obtained the responses, and conducted followup interviews (as necessary) between September 29, 2020, and July 27, 2021. We asked the State agencies to provide data for all children in foster care placements (i.e., children who were eligible for Title IV-E of the Act as well as those who were not covered) who went missing at any time from July 1, 2018, through December 31, 2020 (audit period). All 50 State agencies responded to our questionnaire although, as explained below, not all of the State agencies responded fully to all of the questions.

The questionnaire and followup interviews focused on three key areas:

- data on missing children,
- State agencies' policies and procedures for reporting and locating these children, and
- State agencies' perspectives on the challenges they identified with respect to missing children.

We also met with ACF staff to gain an understanding of ACF's roles and responsibilities, the guidance and training it has provided to State agencies, and ACF's perspectives on the challenges confronting State agencies.

[11] The Missing Children Act of 1982, P.L. No. 97-292 (Oct. 12, 1982), codified at 28 U.S.C. § 534.

The information in this report was current when we conducted our questionnaire and interviews but may not represent all of the issues that ACF and State agencies have faced or the actions they have taken to address those issues. We did not verify the information that the State agencies provided to us or evaluate the effectiveness of the actions that the State agencies identified.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Additional details on our audit scope and methodology appear in Appendix A.

FINDINGS

According to data that the State agencies provided, there were 110,446 missing children episodes during our audit period.[12] Some States had higher percentages of these episodes relative to their total populations of children in foster care than did others. The percentages of missing children by State ranged between 0 and 7 percent during our audit period. In addition, 36 State agencies reported that the average number of days that the children were missing ranged from 7 to 46 days, but 9 States reported that children were missing for more than 50 days on average.

With respect to our second objective, all 50 State agencies described various policies and procedures that they had adopted to address missing children episodes. Specifically, all State agencies said that they had implemented policies and procedures that required a State agency or foster care provider to report any missing child to law enforcement and NCMEC within 24 hours of identifying that the child was missing. Six State agencies reported that they had adopted reporting procedures involving compressed timelines when a high-risk child went missing. In addition, some State agencies had policies that detailed provisions designed to increase the likelihood of locating and safely returning a missing child. Moreover, five State agencies had created special units or had specifically designated staff to help locate missing children in their States.

With respect to our third objective, we identified several barriers and other deficiencies in the State agencies' policies and procedures related to missing children. The barriers included a

[12] This number does not include episodes for all 50 States because 3 States (Pennsylvania, Rhode Island, and West Virginia) did not provide us sufficient details and 1 State (New York) gave us data (regarding both missing children and total numbers of children in foster care) only on children who were Title IV-E eligible. For details, see Appendix C. Additionally, State agencies often varied in terms of how they defined "missing child." One State agency told us that it considers children to be missing, absent, or run away as soon as they are identified or known to be missing, while another State agency said that it considers children to be missing only after they have been missing for 24 hours.

number of limitations in State agencies' data systems that resulted in inaccurate and incomplete data. Furthermore, although most State agencies had policies in place for mandatory reporting to NCIC, NCMEC, and law enforcement, some State agencies described difficulties meeting their reporting requirements because of issues involving State confidentiality laws, the use of children's photographs, and the collaboration and exchange of information with NCIC, NCMEC, and law enforcement. Additionally, some State agencies reported that they continued to remit maintenance payments to providers after a child went missing from foster care.

With respect to our fourth objective, the most frequently identified challenges were: (1) locating children who repeatedly go missing from foster care; (2) obtaining cooperation from missing children's families and friends; (3) obtaining assistance from law enforcement; (4) finding the correct foster care placement for children to prevent them from running away; and (5) a lack of awareness among some State agencies of the support and technical assistance that ACF provides.

The barriers to State agencies' efforts that we identified, as well as the challenges that the State agencies identified, could hamper efforts to report and locate missing children.

FEDERAL REQUIREMENTS AND GUIDANCE

We summarize relevant Federal requirements and guidance below. For additional details on these Federal requirements and guidance, see Appendix B.

Federal Statutes and Regulations

In 2014, Congress passed the Strengthening Families Act (see footnote 9), which amended Title IV-E of the Act by requiring States to develop and implement specific protocols to expeditiously locate any children missing from foster care (the Act § 471(a)(35)(A)(i)).

The Strengthening Families Act also defined specific reporting requirements. State agencies must report immediately, and in no case later than 24 hours after receiving, information on a missing child to law enforcement authorities and to NCMEC (the Act § 471(a)(35)(B)). Each State must outline in its State plan how it will fulfill these requirements insofar as children who go missing from foster care placements are concerned.

ACF Guidance

ACF, Children's Bureau published an Information Memorandum (IM) concerning the Strengthening Families Act that includes information regarding the requirements for State agency actions when children run away from foster care. This IM provides guidance on services for children under 18 years old who run away from foster care and who then come into contact with runaway and homeless youth programs. This IM also includes information related to State agency oversight of high-risk children in foster care (ACYF-CB/FYSB-IM-14-1).

Federal guidance also addresses cases in which a child is temporarily absent from a foster care placement because the child has run away or due to other circumstances (e.g., the child is on a weekend home visit or is hospitalized for medical treatment). In such cases, the State agency may provide a full month's Title IV-E foster care maintenance payment to the licensed provider, but only in cases in which the absence does not exceed 14 days and the child returns to the same foster care provider (ACF Child Welfare Policy Manual, section 8.3B, Question 7).

SUMMARY OF DATA ON MISSING CHILDREN

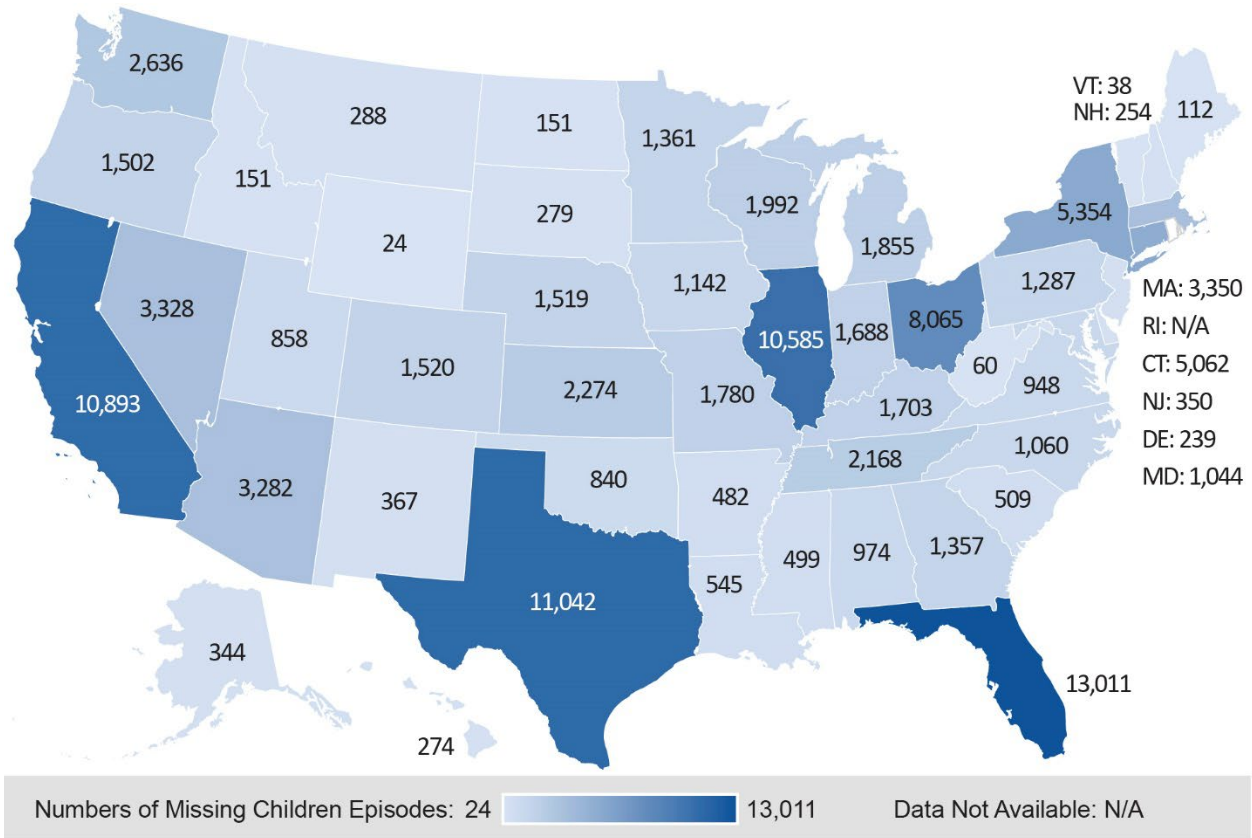
State Agencies' Data on Missing Children

According to data on missing children that the State agencies provided, there were 110,446 missing children episodes involving 43,679 of the 1,016,895 children who were in foster care. The following summarizes the data provided by the State agencies.

All 50 States provided data identifying children they defined as "missing" during our audit period; however, 4 State agencies did not provide data on all of their respective missing children episodes.[13] The data provided by the States included the number of children in foster care who went missing at least once, and showed that many of the children went missing multiple times. Figure 1 on the following page shows the numbers of these 110,446 missing children episodes by State.

[13] See footnote 12.

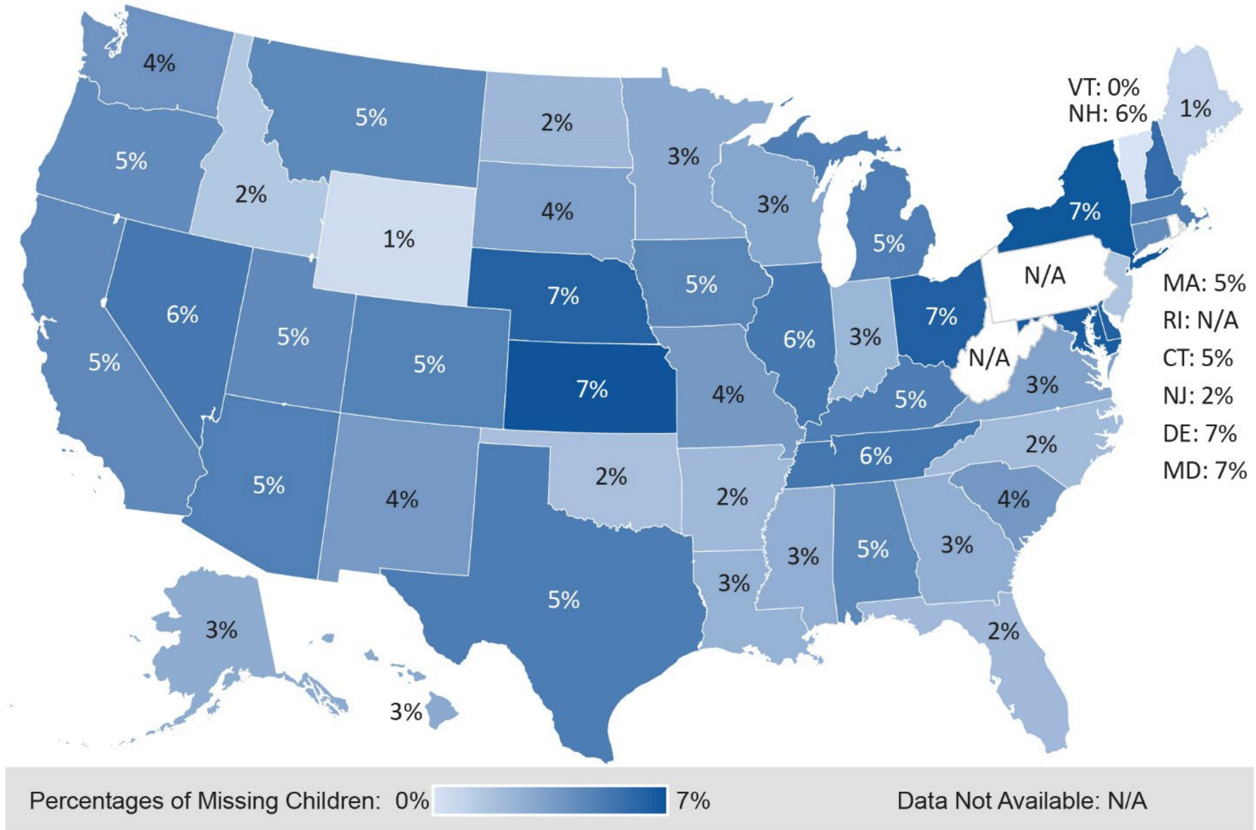
Figure 1: Numbers of Missing Children Episodes



The percentages of children in foster care who went missing at some point during our audit period varied by State from 0 to 7 percent.[14] Of 47 State agencies that provided data that allowed us to calculate their percentages of missing children, 10 State agencies reported that between 6 and 7 percent of their children in foster care placements had gone missing at some point during our audit period. Another 34 State agencies reported that between 2 and 5 percent of their children in foster care placements had gone missing, and 3 State agencies reported that 1 percent or less of their children in foster care placements had gone missing. Figure 2 on the following page shows the percentage of missing children in relation to the total number of children in foster care placements during our audit period.

[14] We calculated this percentage by dividing the total number of missing children in foster care (unique children, not episodes) by the total number of children in foster care for each State. Three State agencies (Pennsylvania, Rhode Island, and West Virginia) did not provide sufficient information for us to calculate percentages. For details, see Appendix C.

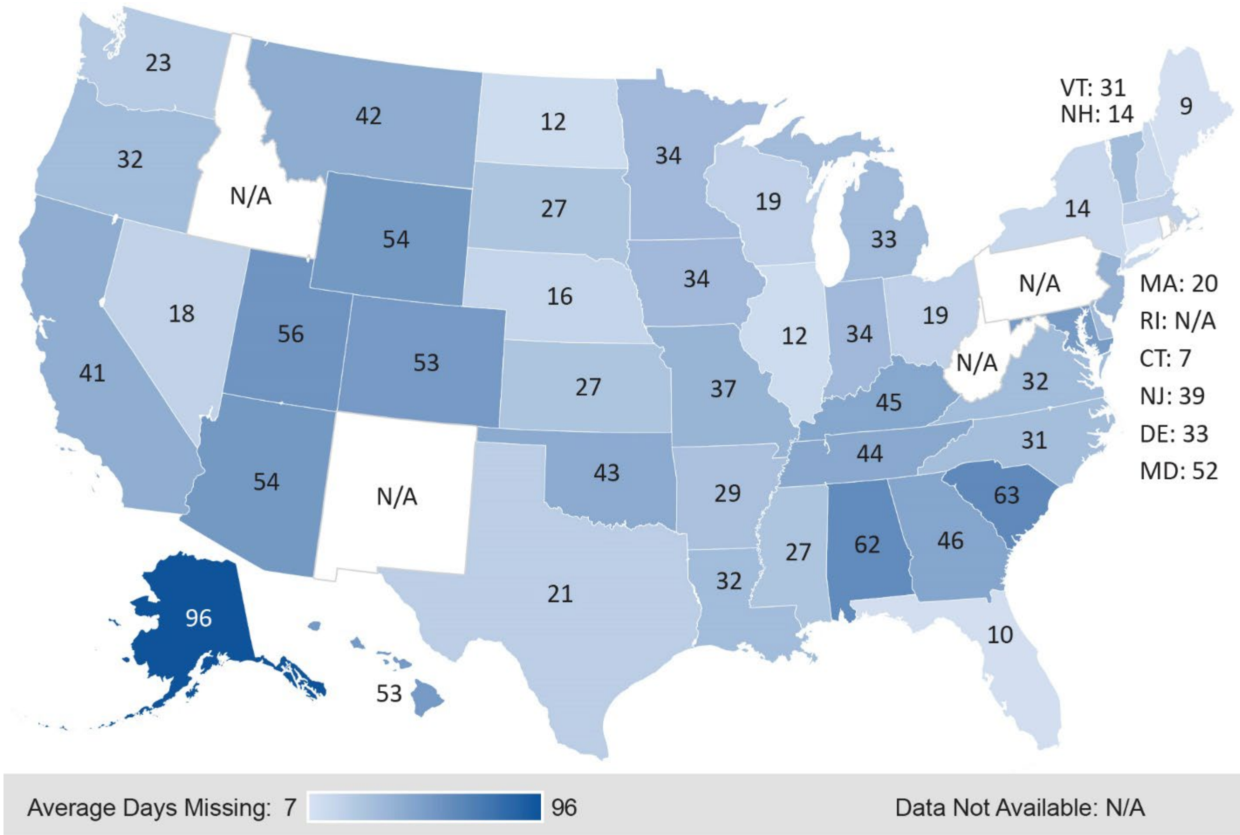
Figure 2: Percentages of Missing Children by State



The State agencies' data showed that some States had children who on average were missing from foster care for substantially long periods of time. The average number of days children were missing varied by State and ranged between 7 to 96 days. For the 45 State agencies that provided this information, the average number of days that children were missing was 34 days.[15] Thirty-six State agencies reported that the average number of days that children were missing ranged from 7 to 46 days, but 9 States reported that children were missing for more than 50 days on average. See Figure 3 on the following page.

[15] For five States (Idaho, New Mexico, Pennsylvania, Rhode Island, and West Virginia), we were not able to calculate the length of time that children were missing from foster care because those State agencies did not give us the dates on which the children were located.

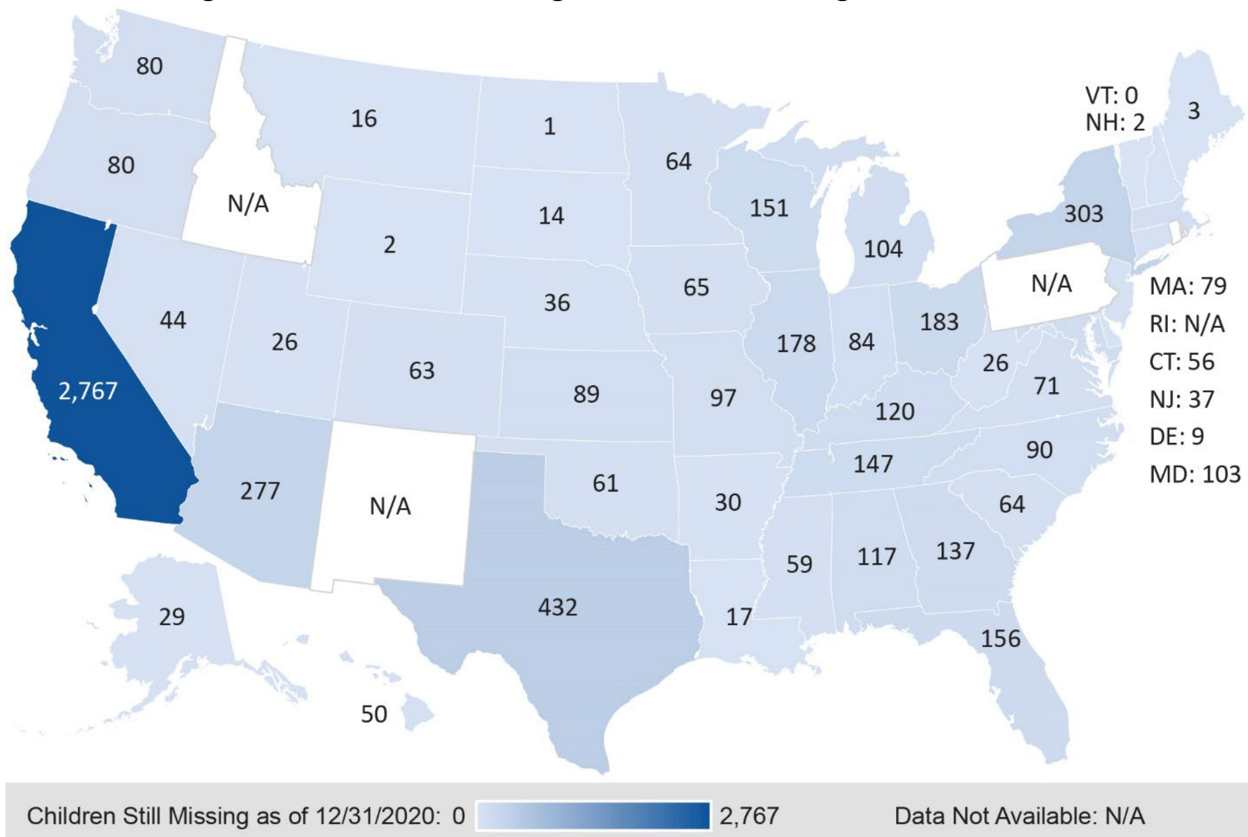
Figure 3: Average Number of Days Missing per Episode



For the 46 State agencies that provided data on missing children, the number of children who went missing from foster care during our audit period and remained missing as of December 31, 2020, which was the last day of our audit period, was 6,619 (see Appendix C).[16] This included one State that had more than 2,500 missing children and one State that reported no missing children as of that date. Figure 4 on the following page shows the number of missing children as of December 31, 2020.

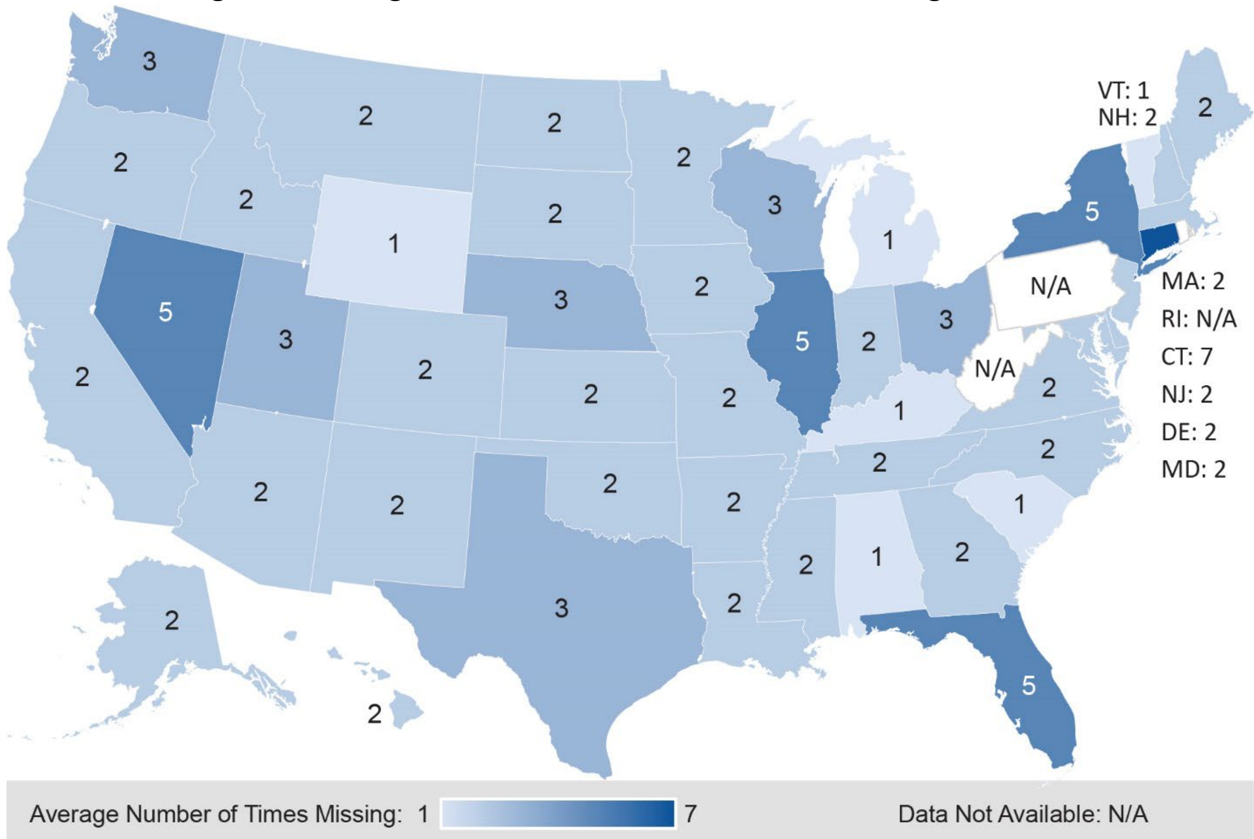
[16] Five State agencies did not give us the dates on which the missing children were located, but one State agency reported its number of children still missing from foster care as of December 31, 2020. For the 46 State agencies that reported the data depicted in Figure 4, we identified whether the children were still missing by using the missing children episodes' end dates that the State agencies provided to us.

Figure 4: Numbers of Missing Children Still Missing as of December 31, 2020



The fact that State agencies reported 110,446 missing children episodes involving 43,679 unique children during our audit period suggests that many of the episodes involved children who went missing more than once. Of the 47 State agencies that provided data identifying the number of times each child went missing, 5 State agencies reported that the children who went missing from their foster care placements did so an average of 5 to 7 times over the course of our audit period. Figure 5 on the following page shows the average number of times a child in foster care went missing.

Figure 5: Average Number of Times a Child Went Missing From Foster Care



Of the 110,446 missing children episodes that were reported nationwide during our audit period, 65 percent involved children who were 15 to 17 years old when they went missing. State agencies also reported a total of 760 missing children aged 5 years old or younger, some of whom the State agencies categorized as "runaway." According to one State agency official we interviewed, these episodes categorized as runaway were more likely to be the result of abductions because a child in this age group is not likely to run away. When missing children episodes are not categorized correctly, State agencies may not provide the necessary services or initiate the most effective responses. Furthermore, although more males than females are generally in foster care, the data showed that of the missing children, 51 percent were females, 48 percent were males, and 1 percent were reported without gender data or reported as transgender or undecided. See Figures 6 and 7 on the following page.

Figure 6: Percentages of Missing Children by Age Range

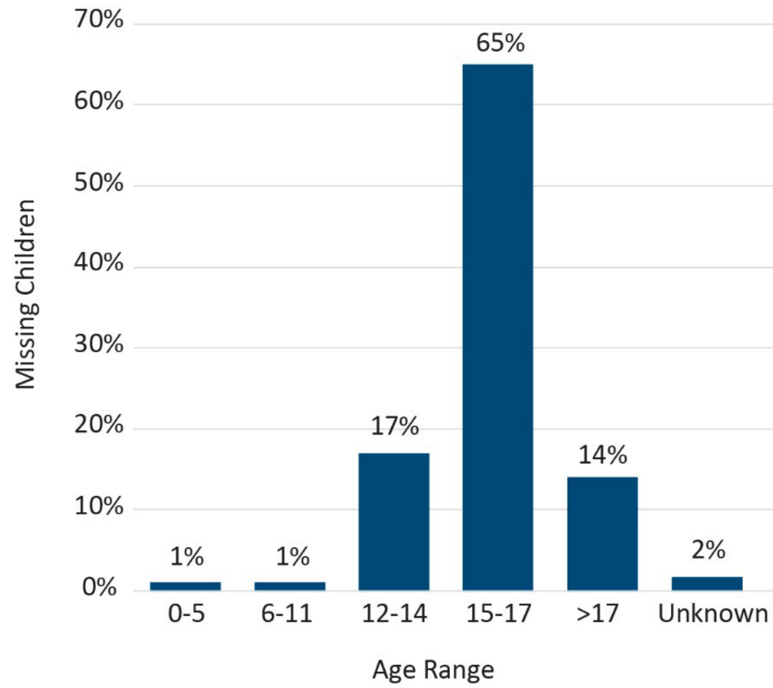
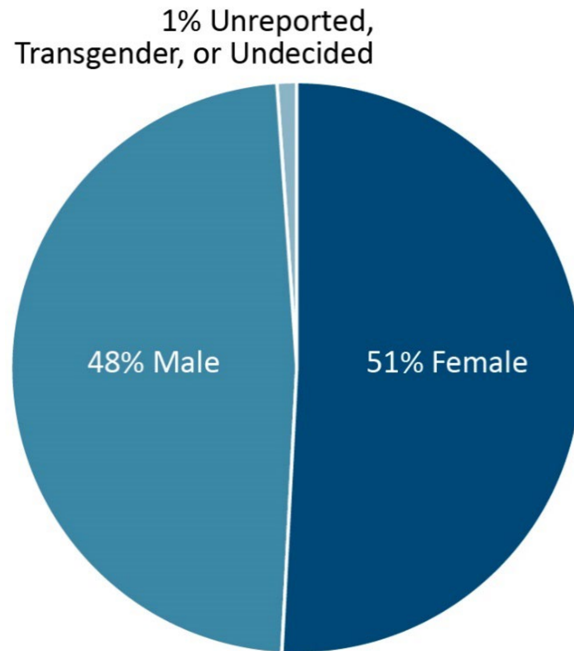


Figure 7: Genders of Missing Children

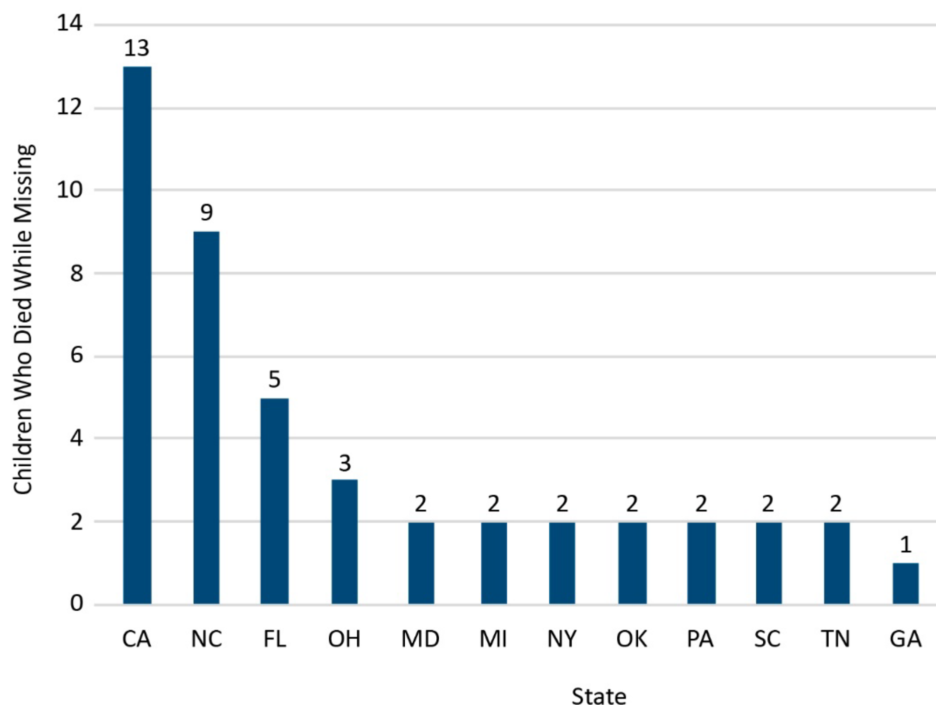


Unfavorable Outcomes of Missing Children Episodes

Children who go missing from foster care are vulnerable to crime and exploitation, which may result in physical harm and even death. Although our audit did not examine the specific experiences that children underwent while missing, we did ask the State agencies to provide information on why cases were closed while the children were still missing. Twelve State agencies reported that some of their missing children episodes culminated in deaths of children.[17]

Figure 8 shows the States that identified missing children episodes for which the child's case was closed because of the child's death. Every such instance—as well as those that were not recorded or reported—reinforces the fact that the outcomes of some of the missing children episodes can be catastrophic. For example, one 15-year-old child was reported missing from California on January 25, 2019, and was found dead (of a suspected drug overdose) 3 days later, on January 28, 2019, in Texas. The California State agency (to which the deceased child was assigned) told us that the detective investigating this case spoke of efforts to locate "the man" who was reportedly accompanying the child in hopes of identifying the individual who sold or gave the lethal drugs to that child. Outcomes of this nature are unquestionably tragic and underscore the importance of quickly identifying and locating children who go missing from foster care.

Figure 8: Numbers of Children Who Died While Missing



[17] We emphasize that any discussion of the data in this section and depicted in Figure 8 relies on the unverified information provided by the States, and we did not obtain similar data from all States.

Analysis of State Agencies' Data

The data that the State agencies gave us serve as a snapshot of the children in foster care whom the agencies defined as missing during our audit period. These data provide information regarding the number of missing children episodes; the percentage of missing children relative to the overall population of children in foster care in each State; the average length of time that children were missing from foster care; the number of times the children went missing; the number of missing children as of December 31, 2020; and some additional demographic characteristics of the missing children population. The data (see Figure 1) suggest that some States had a considerably higher number of missing children episodes than other States.

However, when comparing the actual number of missing children (as opposed to the number of episodes) to the total number of children in foster care in each State, the percentage of children who went missing at some point during our review period generally ranged from 0 to 7 percent nationwide (see Figure 2). The data also suggest that most children were located, although 6,619 remained missing as of December 31, 2020; that the risk of going missing increased with age, with late adolescence representing the point of relatively highest risk; and that slightly more female than male children went missing (see Figure 6 and Figure 7).

Data analysis such as this can help stakeholders learn more about the population of missing children, identify children who are at a high risk of going missing, and gain knowledge about which States might need more support and technical assistance from ACF to address challenges (discussed further below) related to locating and reporting missing children.

Limitations in Analysis of Data

To conduct our analysis, we obtained the data directly from the State agencies. ACF does not collect detailed information on the population of missing children. However, there are limitations in the data that the State agencies collect in their systems. Specifically, some of the data we received from the State agencies were incomplete, inaccurate, or not directly comparable from one State to another. These limitations prevented us from performing comprehensive data analysis of factors such as race, ethnicity, placement settings, and the precise status of missing children (i.e., runaway, abducted, etc.). Additionally, State agencies often varied in terms of how they defined "missing child." One State agency told us that it considers children to be missing, absent, or runaway as soon as they are identified or known to be missing, while another State agency said that it considers children to be missing only after they have been missing for 24 hours.

STATE AGENCIES' POLICIES AND PROCEDURES FOR REPORTING AND LOCATING MISSING CHILDREN

State Agencies' Policies and Procedures for Reporting Missing Children

All 50 State agencies described various policies and procedures that they had adopted for reporting missing children. Specifically, all State agencies said that they had implemented policies and procedures that required a State agency or foster care provider to report any child missing from foster care to law enforcement and NCMEC within 24 hours of identifying that the child was missing. Some State agencies also required reporting these children to other entities, such as parents and guardians.

In addition, six State agencies reported that they had adopted reporting procedures involving compressed timelines when a high-risk child (such as a young child) went missing. For example, one State agency said, "For youth that have gone missing, if they are in a high-risk category, immediate notification to [State agency] and law enforcement is required." Another State agency told us that a missing child must be reported immediately for children under 11 years old, within 1 hour for children 11 to 13 years old or determined to be high-risk, and within 4 hours for youths 14 years old and older and not determined to be high-risk.

State Agencies' Policies and Procedures for Locating Missing Children

We asked all 50 State agencies to describe their procedures and requirements for locating missing children once law enforcement had been notified. Twelve State agencies stated that their only requirement was for the foster care provider, the State agency, or both to contact law enforcement; these State agencies did not have procedures that required foster care providers to assist in locating, rather than just reporting, missing children.

The remaining 38 State agencies required State agency staff or a provider to do more than just report a missing child. One State agency, for example, required that: "Each facility shall have a written plan on file which specifies action and procedures for meeting emergency situations including serious illness, severe weather and missing children." Another State agency required its staff to send, each week, "a reminder . . . to [local] Social Work staff who have runaways on their caseloads to update the Runaway Database and document all efforts to locate the child." Yet another State agency identified in its written policy specific search procedures for both foster care providers and its own staff to follow. These efforts included searching the child's belongings, attempting to contact the child's cell phone, checking the child's social media accounts, searching areas the child is known to frequent, and contacting the child's friends, family, school, or work.

Additional State Agency Practices

Among the 38 State agencies that required their staffs or foster care providers to do more than just report a missing child, some State agencies' procedures described additional practices that have the potential to enhance efforts to report and locate missing children. One State agency, for example, created a portal within its electronic child welfare data system that automatically notifies NCMEC when a child's placement status changes to "missing." This automatic notification increases the probability that missing children will be located quickly.

Five State agencies reported to us that they had created special units or had specifically designated staff to help locate missing children in their States. For example, one State agency established a Special Investigations Unit (SIU) staffed by two former members of law enforcement as well as a specialized coordinator whose experience included working with child victims of sexual exploitation through community partners. The SIU staff were available 24 hours a day and could search background-check databases, national criminal history data, and social media.

Another State agency had created a team that was charged with reducing the number of missing children by increasing collaboration with local law enforcement, tracking missing children, and attempting to locate children who remain missing from foster care. This team consisted of nine full-time employees and a supervisor.

Implementing one or more of these practices could improve outcomes for missing children and reduce the number of missing child episodes.

BARRIERS AND OTHER DEFICIENCIES IN STATE AGENCIES' POLICIES AND PROCEDURES RELATED TO MISSING CHILDREN

We identified several barriers and other deficiencies in the State agencies' policies and procedures related to missing children. These barriers and deficiencies included:

- limitations in State agencies' data systems;
- lack of oversight to ensure timeliness when reporting missing children;
- difficulties involving State agency policies and procedures associated with mandatory reporting to law enforcement, NCIC, and NCMEC; and
- continuation of maintenance payments to providers after children in foster care placements went missing.

These barriers could hamper efforts to report and locate missing children.

Limitations in Data Can Affect Efforts To Identify and Locate Missing Children

Not all State agencies had accurate and complete data for tracking missing children. Some States were not able to provide all of the data that we had requested, which prevented us from accurately determining the total number of missing children episodes nationwide.[18] Without accurate and complete data, the State agencies may not be able to adequately track missing children. Furthermore, these data limitations prevented comprehensive data analysis of various factors, including race and ethnicity. The nature of the data limitations that we identified are discussed below.

Uniform Categorization of Missing Children

Most State agencies' systems either did not list "missing" as an available status for children in foster care or categorized all missing children episodes as "runaway" or "AWOL" (i.e., children who left their foster care placements without permission). Their systems did not distinguish, for instance, between an episode involving an abducted child and an episode involving a child who was not currently in foster care placement for other reasons (such as a lack of information about the child's current location or an illness requiring hospitalization). Greater precision in State agency systems to describe the nature of and reason for a missing child episode could facilitate reporting and enhance efforts to locate a child.

Inconsistent and Contradictory Data Fields

Some State agencies' data had errors involving inconsistency or contradictions between one data record or field and another. Two State agencies had errors in their data systems in which an entry for the same child showed different races in different data fields. For example, the first episode involving a missing child may have categorized the child's race as "Black" but the second episode recorded the same child's race as "White." Other errors found in the "missing date" and/or "located date" data field caused some records to reflect the date the child went missing as a date after the date the child was located. These input errors could have been prevented if these State agencies had improved the edits in their data systems.

We also observed that State agencies did not classify race and ethnicity consistently. Most State agencies' systems had a data field to record different ethnicities, but others recorded ethnicity only when the child was Hispanic. Many of the State agencies' data contained records in which the marked data field for ethnicity said "Other" or "Unable To Determine" or were blank. One State agency's data system did not have a data field for race or ethnicity.

Having accurate data that describe the characteristics of a missing child and an accurate date for when a child in foster care went missing are essential when trying to locate a missing child.

[18] See footnote 12. Several State agencies commented on their data systems' inability to capture all of the information we requested in our questionnaire; these State agencies added that they were developing new or enhanced systems to address some of these issues.

Incomplete Data

Many States had incomplete data, which could affect tracking and locating missing children. It is commonplace to release the details of missing children to different entities in hopes that the public can help locate those children. In their responses to our questionnaire, many State agencies could not give us the dates that missing children episodes were reported to NCMEC or law enforcement, or could not give us NCMEC or NCIC case numbers, because that information was either not tracked in or not easily extracted from their data systems. If State agencies were required to maintain complete and accurate data on missing children in their systems, they would be able to share these data more readily with entities that can help locate those children.

Limitations involving incomplete data on missing children affect both tracking and locating those children. Five State agencies, for instance, did not have information available in their data systems that would identify missing children as located or still missing.

One State agency provided us with data that we could not use because they did not contain all of the missing children episodes, nor did they identify the genders, dates children were missing, or located dates of missing children.

Another State agency provided us with partial data on its missing children. The State agency said that beginning in the middle of 2019, it implemented an internal spreadsheet to track names, dates children were missing, and placements of children, but added that it did not track missing children episodes. The State agency also said that it was in the process of building a new data system.

Another State agency gave us data that did not include the dates that children went missing or the dates that they were located. This State agency said that its program was county-operated and that the counties maintained their information for children in foster care in a total of six different databases. According to the State agency, "This framework allows each of the counties to create and administer supports and services that meet the needs of the county as well as the individuals being served by the county." We note that such decentralization of data makes it more difficult for a State agency to have a complete picture of the total number of missing children episodes and identify the causes of these episodes.

If all State agencies maintained complete information on missing children, program administrators and stakeholders at all levels would be equipped with more accurate data to make decisions and allocate resources to ensure that these children are properly reported and located.

Duplicate Records

The data provided by some State agencies contained duplicate records for the same missing children episodes. Similarly, the data system in at least one State agency did not assign unique

identification numbers to missing children, while a separate State agency permitted a single missing child to have two or more identification numbers. The latter State agency explained that "if a foster child who had previously gone missing went missing again, the individual performing the data entry could create a new record with a new identification number because he or she could not find the original record."

Lack of a unique identification number for a missing child could lead to the submission of multiple reports for that child to law enforcement and NCMEC, which in turn could lead to inefficient use of the resources assigned to locate that child. Data systems with these shortcomings would therefore benefit from having a system edit in place to prevent the assignment of multiple identification numbers for the same child.

State Agencies Often Lack Oversight To Ensure Timeliness When Reporting Missing Children

Many State agencies said that they did not routinely identify or track instances in which foster care providers did not report missing children episodes in a timely manner. However, three State agencies stated that in response to this audit they would evaluate how they could better identify and address issues involving timely reporting. For example, one State agency told us that it could not determine whether a missing child was reported in a timely manner without manually reviewing more than 1,900 cases. This State agency also said that effective January 1, 2021, it would manually track this data element until the State agency could transition to a more comprehensive system for tracking the timely reporting of missing children episodes. In another example, one State agency stated: "We do not maintain an electronic tracking system dedicated to monitoring the entry and timing of the report [of a missing child] . . . . The agency is planning on taking steps to improve practice around the capture of this specific data set."

Without ensuring that missing children are accurately and expeditiously reported, State agencies lack assurance that all appropriate agencies are promptly initiating searches for missing children. Absent such assurance, information is not as precise or timely as it could be to facilitate efforts to locate missing children and return them to a safe setting.

State Agencies' Policies for Mandatory Reporting of Missing Children

Policies and Timelines for Mandatory Reporting

Among the 50 State agencies, 42 State agencies specified that their staffs were responsible for reporting missing children to law enforcement and the other 8 State agencies said that either the foster care provider or State agency staff did so. The reporting timeframes varied from "immediately" to within 24 hours after a child went missing.

Furthermore, 44 State agencies responded that law enforcement reported missing children to NCIC while 2 other State agencies said that they directly report these episodes to NCIC. The other four State agencies either were not sure or did not respond to this question. Some of the

State agencies added that their staffs had verified that law enforcement had reported missing children to NCIC.

Among the 50 State agencies, 46 said that their staffs reported missing children to NCMEC, 1 State agency said that the foster care providers did so, 2 State agencies said that law enforcement did so, and 1 State agency said that either the provider or State agency staff reported to NCMEC. All of the State agencies that said they report to NCMEC told us that missing children were reported within 24 hours, with the exception of one State agency that said it reported to NCMEC 3 days after notifying law enforcement that a child had gone missing. The policy for this State appeared to conflict with the Strengthening Families Act (Appendix B), which states that immediately—and in no case later than 24 hours after receiving notification of a missing child—a report must be made to NCMEC.

Difficulties Associated With Mandatory Reporting

Although most State agencies had policies in place for mandatory reporting to NCIC, NCMEC, and law enforcement, two State agencies described difficulties they had encountered when trying to implement these policies. Some of these difficulties involved State confidentiality laws that prevented submission of children's photographs to NCMEC.

The other State agency pointed to a related issue involving children's photographs. According to this State agency, law enforcement in that State could not enter information about a missing child into the NCIC database without a recent photograph of the child. At times, the State agency had difficulty obtaining a photograph of the child such as, for instance, when a judge had ordered a child who was on runaway status into State agency care and the State agency had not recently had the opportunity to take a photograph of the child.

Furthermore, three State agencies described difficulties they encountered in collaborating and exchanging information with NCIC, NCMEC, and law enforcement. One of these three State agencies said that although NCMEC communicated directly with law enforcement, the State agency was not always informed of these exchanges of information. The second State agency told us that NCMEC policy was to provide tips received on a missing child's location only to law enforcement, adding that it had repeatedly asked for these tips directly from NCMEC but that NCMEC had continued its current policy.

The third State agency said that if law enforcement could give the State agency a verification number after reporting to NCIC that a child had been designated as missing, the State agency could coordinate with NCMEC to upload a photograph or poster of the missing child to the NCMEC website. According to the State agency, NCMEC would not upload the photo or poster, assign a case manager, or send leads until the missing child's information had been entered into the NCIC database.

Additionally, one State agency said it could not share information with NCMEC because NCMEC is not considered a juvenile justice or care agency, as defined by State law, for purposes of

sharing confidential information. Accordingly, this State agency did not give children's photographs to NCMEC.

Another State agency stated that only certain staff had access to the NCMEC website to make a missing child report. Thus, according to the State agency, if a child in that State ran away on a Friday evening, the case worker and law enforcement would be notified immediately but the State agency might not be able to enter the episode into the NCMEC website until the following Monday.

Deficiencies in Procedures Regarding Continuation of Payments for Missing Children

Maintenance payments to foster care providers are payments to cover the costs of food, clothing, shelter, daily supervision, school supplies, personal incidentals for a child, and reasonable travel expenses in order for a child to remain in the school in which the child was enrolled at the time of placement (the Act § 475(4)).

ACF's Child Welfare Policy Manual states: "The title IV-E agency may provide a full month's title IV-E foster care maintenance payment to the licensed provider if the brief absence does not exceed 14 days and the child's placement continues with the same provider. Otherwise, the title IV-E agency must prorate its claims if the child is absent from placement for more than a reasonable brief period" (ACF Child Welfare Policy Manual, section 8.3B, Question 7).

Forty State agencies reported that their procedures were to continue to make maintenance payments to providers after a child in foster care had gone missing. Most State agencies said that they generally permitted continued maintenance payments when the bed was being held for the missing child and the provider was willing to hold the placement for the child. Most of these State agencies said that they stopped maintenance payments between 3 and 30 days after the child went missing. One State agency said that under its policy, maintenance payments could continue regardless of the length of time a child was missing. The policies and procedures for the State agencies that made monthly maintenance payments beyond 14 days of a child's absence contrast with the ACF guidance in the Child Welfare Policy Manual, section 8.3B, Question 7. For example, one State agency told us that maintenance payments made on behalf of a child stopped after 30 days had passed since the child had gone missing; however, based on the data we received from that State agency, almost $650,000 in maintenance payments had been made on behalf of children who had been missing for more than 30 days.

STATE AGENCIES' MOST FREQUENTLY IDENTIFIED CHALLENGES REGARDING MISSING CHILDREN

We asked the State agencies to identify their greatest challenges associated with ensuring that missing children were reported as missing within the required timeframes and ensuring that these children were located. The most frequently identified challenges were: (1) locating children who repeatedly go missing from foster care; (2) obtaining cooperation from the missing children's families and friends; (3) obtaining assistance from law enforcement; (4) finding the

correct foster care placement for children to prevent them from running away; and (5) a lack of awareness among some State agencies of the support and technical assistance that ACF provides.

Frequently Missing Children

Several State agencies described frequently missing children as a challenge. The following are examples of what the State agencies said regarding the challenges of frequently missing children.

Several State agencies referred to the effects of these challenges on caseworkers. For example, one State agency said that caseworkers' "biggest frustrations are typically related to children who go missing frequently or who return to care and then are missing very shortly thereafter . . . ." Another State agency stated: "[C]hallenges remain with older youth who habitually absent themselves from care without permission; these youths are listed as missing, yet assigned caseworkers are often aware of their whereabouts. We feel that it's essential to document and attempt to locate and retrieve any child absent from care regardless of age or status."

One State agency said, "We do have some children who are missing frequently and [have] become adept at hiding from authorities." Another State agency pointed out that "a caseworker may know where a youth is located (i.e., home of a relative that was not approved for placement) but [the State agency] may be unable to access or make contact with the child." A third State agency described a related challenge: "[W]hen we have a child, we are aware of their location" but "they refuse to return to a certified placement."

Uncooperative Friends and Families

Several State agencies described the difficulties in obtaining cooperation from missing children's friends and families. The following are examples of what the State agencies said regarding the challenges in obtaining cooperation from missing children's friends and families.

Regarding uncooperative friends and families, one State agency stated: "Many children run to their family and friends. Due to the existing relationship, these people may not cooperate [with the State agency] or local law enforcement's efforts to locate the missing child." Similarly, another State agency said: "Oftentimes [missing children] are with friends and family who are harboring them and concealing information which may help locate them."

Assistance From Law Enforcement

Thirteen State agencies identified challenges related to obtaining assistance from law enforcement. These State agencies generally described these challenges as: reliance on law enforcement's assistance, law enforcement's limited resources, and law enforcement's actions

and responses to a missing child of legal age (i.e., a child who has reached the legal age of 18 but remains in extended foster care).

Regarding the need to rely on law enforcement's assistance, one State agency stated: "The greatest challenge is . . . relying on law enforcement to assist in picking the youth up or . . . to see if the youth is at the location [the State agency] provides to [law enforcement]. There are numerous occasions where [the State agency] appears to be dismissed when requesting assistance. A specific challenge is when law enforcement states they cannot put the youth into NCIC unless they have an updated photo of the child."

With respect to law enforcement's limited resources, one State agency commented: "Law enforcement may not have the needed manpower to search for missing children . . . ."

With respect to law enforcement's actions and responses to missing children of legal age, one State agency stated: "Local law enforcement sometimes presents a barrier to locating a teen because they refuse to report youth who are eighteen or older even though they are in state custody." Another State agency drew a connection between law enforcement responses and children who resist returning to foster care: "Collaboration with Law Enforcement has been a barrier at times. Specifically, when reporting our young adults over 18 as well as when we have a child, we are aware of their location however they refuse to return to a certified placement."

Finding Correct Placement To Prevent Children in Foster Care From Running Away

Many State agencies identified as a challenge the need to find the correct placement to prevent children in foster care from running away again. State agencies also expressed related concerns regarding children and adolescents who frequently run away, children who are unable or unwilling to contribute positively to placement decisions, and children who suffer because of a lack of individuals willing to be caregivers.

Challenges in finding the correct foster care placement for children were interwoven with concerns about a lack of caregivers. One State agency commented that "children are happier in home-like settings [than they are in] group homes, but there is a significant challenge in findings [sic] individuals willing to be caregivers. A great deal of effort statewide has gone into foster parent recruitment and the [State agency] has pledged to move away from group homes as a practice, but it takes time to recruit alternatives."

With respect to older youth and children who frequently run away, one State agency commented: "Case planning and team planning are critical in these cases to find a safe place for the youth to reside where they are willing to remain and plan for the child's future. Finding the right placement option for the child can be challenging."

One State agency expressed concerns regarding the need to encourage children (as well as program staff and caseworkers) to be involved in and contribute to placement decisions:

> One of the greatest challenges is changing the narrative from youth being considered 'just a runaway' or 'on run' to ensuring that all involved in supporting foster youth have empathy and a non-judgmental approach when a youth goes missing from care. Being able to have an open dialogue to understand why a youth believes that going missing is a better choice than staying in a foster placement. This is an important piece in keeping youth safe. This not only ensures the youth's voice is heard but will help with their permanency and well-being.

Awareness of ACF Guidance and Technical Assistance Regarding Missing Children

We asked the State agencies about the support and technical assistance they had received from ACF for preventing children from running away and locating missing children. The responses pointed to a lack of awareness or misunderstandings of available support and assistance from ACF by most State agencies. Of the 48 State agencies that responded to this question, only 13 State agencies said that they were aware that ACF provides support and technical assistance if needed, including assisting in implementing various child welfare policies and practices and support through the Child Welfare Capacity Building Collaborative. One of these State agencies stated that, on request, its ACF Regional Office is always willing to provide training, clarification, or interpretation of relevant Federal requirements.

In contrast, 19 State agencies said that they were not aware of any support or technical assistance that ACF provides. For example, 1 of these 19 State agencies said that ACF did not provide specific guidance to assist States in: (1) determining evidence-based techniques to prevent missing children episodes or (2) identifying services that can be provided to children who have run away from foster care. This State agency suggested that ACF give additional support to States on these techniques and available services.

In addition, 11 other State agencies said that they believed that ACF's support was limited to providing the State agencies with policy issuances, such as IMs.

Five other State agencies did not directly state whether they were aware of support or technical assistance from ACF. These State agencies did say that they were interested in receiving support and technical assistance from ACF that they believed would help prevent missing children episodes. These agencies desired support and assistance needed for foster care family training and education, recruitment measures for potential providers (especially in the children's own communities), ongoing and regular support for each child and family, peer mentoring programs, strategies to maintain contact with children's biological families

(especially with placement with kinship caregivers),[19] youth advisory boards, the hiring of additional State agency staff (which would allow for more flexible schedules to meet children's needs), and job training and education.

Before developing and distributing our questionnaire to all the State agencies, we met with ACF officials and asked for information about, among other things, the guidance and training that ACF has provided to State agencies regarding missing children in compliance with the Strengthening Families Act (Appendix B). ACF officials told us that ACF disseminates program information though its listservs, regional offices, and website.[20] These officials also stated that ACF staff gave several presentations about the Strengthening Families Act through national webinars and grantee meetings in 2014 and 2015. ACF officials added that ACF has coordinated with NCMEC to disseminate information about how State agencies should report missing children to NCMEC. ACF officials also referred to the Child Welfare Capacity Building Collaborative, which provides technical assistance to States to help them improve their compliance with Federal requirements, and said that States have the option of receiving technical assistance tailored to their specific needs.[21] To date, according to the ACF officials with whom we communicated, no State agency has requested technical assistance related to best practices or implementing the requirements of the Strengthening Families Act.

The responses from the State agencies to our questionnaire, combined with the information we obtained from ACF, demonstrate that although ACF is able and willing to offer support and technical assistance to State agencies—and has used its listservs, regional offices, and website to publicize that fact—many of these agencies or all of State agency staff involved in the process of reporting and locating missing children may not be aware of these opportunities.

CONCLUSIONS

The data provided by the State agencies, although not complete, identified 110,446 missing children episodes during our audit period (see footnote 12). These and related data showed the following: (1) the percentages of missing children, by State, ranged from 0 to 7 percent; (2) the average length of time that a missing child was gone ranged from 7 to 96 days; (3) the number of children who were still missing as of December 31, 2020, was 6,619; (4) the average number of times a child went missing ranged from 1 to 7 times; (5) and the majority (65 percent) of missing children were between 15 and 17 years old. The data also showed that

[19] "Kinship caregivers" broadly refers to foster care situations in which children are living with relatives other than their parents.

[20] The Children's Bureau, Division of State Systems, maintains the Child Welfare IT (information technology) Managers Listserv that is exclusive to State and Tribal staff to alert them to important updates, child welfare IT webinars, and scheduled child welfare IT manager conference calls.

[21] ACF describes the training and technical assistance it provides to State agencies at Capacity Building Services | The Administration for Children and Families (hhs.gov).

among the missing children, 51 percent were females, 48 percent were males, and 1 percent were reported without gender data or reported as transgender or undecided.

Federal law (the Strengthening Families Act, see footnote 9) requires State agencies to develop and implement protocols to expeditiously locate any missing children and within 24 hours after receiving information report children described under the law as missing or abducted to law enforcement for entry into the NCIC database and to NCMEC. Although all State agencies told us that they had enacted policies and procedures to report and locate missing children as required, some State agencies had expanded their policies and procedures through what they described as additional practices that had the potential to enhance efforts to report and locate missing children. However, we identified some barriers to State agencies' efforts to report and locate missing children, and State agencies identified challenges that hampered efforts to report and locate missing children.

We obtained the information in this report to provide ACF and other decisionmakers (e.g., State and local officials) with information from all 50 States related to the number of missing children, as well as the State-level approaches to ensuring that missing children are reported and located. This information was current when we conducted our questionnaire and interviews (as of December 31, 2020) but may not represent all of the issues that ACF and State agencies have faced or the actions they have taken to address those issues.

This report includes no recommendations. However, we expect that ACF will consider the information in this report and use this information as it works with State agencies to improve outcomes for missing children, reduce the number of missing children episodes, and address any other deficient policies and procedures related to missing children. ACF elected not to provide formal written comments on our draft report but did provide technical comments, which we addressed as appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

This audit focused on a State-level analysis of data related to missing children and a review of State agencies' policies, procedures, and oversight activities, as well as challenges that the State agencies have identified with respect to missing children. We based our findings on responses to a questionnaire completed by State program administrators in all 50 States (i.e., the State agencies). We distributed the questionnaire, obtained the responses, analyzed the data on missing children, and held followup interviews (as necessary) between September 29, 2020, and July 27, 2021, for our audit period (July 1, 2018, through December 31, 2020). All 50 State agencies responded to our questionnaire although, as explained in footnote 12, not all of the State agencies responded fully to all of the questions.

We did not assess ACF's internal controls as part of this audit.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and guidance;

- met with ACF staff to: (1) gain an understanding of ACF's role and responsibilities regarding missing children, (2) obtain information about the guidance and training that ACF has provided to State agencies regarding missing children, (3) identify the challenges that ACF believes confront State agencies regarding missing children, and (4) obtain a list of State agency contacts;

- developed a questionnaire to gather data about all children in foster care (i.e., children who are Title IV-E-eligible as well as those who were not eligible under Title IV-E) who went missing at any time during our audit period, including those who were categorized as runaway, abducted, lost, or wandered off;

- focused the questionnaire on three key areas:

    - data on missing children,[22]

    - State agencies' policies and procedures for reporting and locating these children, and

[22] Specifically, we asked the State agencies to provide data for all of the missing children who went missing at any time during our audit period. We also asked the State agencies to list each missing child episode separately so that we could identify missing children who went missing multiple times during our audit period.

- State agencies’ perspectives on the challenges they identified with respect to missing children;

- initially surveyed three State agencies—those of Iowa, Utah, and Wisconsin—and then refined our questionnaire;

- surveyed between January 13, 2021, and July 27, 2021, the remaining State agencies based on the refined questionnaire, and conducted followup interviews with all 50 State agencies to clarify their responses as necessary and obtain additional information applicable to our audit period; and

- discussed the results of our audit with ACF officials on October 29, 2021, and gave them detailed information pertaining to the issues we identified.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS AND GUIDANCE

FEDERAL STATUTE AND REGULATIONS

Title IV-E of the Act, as amended by the Strengthening Families Act (see footnote 9) (the Act § 471(a)(35); 42 U.S.C. § 671(35)), requires States to develop and implement specific protocols for locating and ensuring the safety of youth who are missing from care, including all of the following:

(62) (A) not later than 1 year after September 29, 2014, the State shall develop and implement specific protocols for—

(i) expeditiously locating any child missing from foster care;

(ii) determining the primary factors that contributed to the child's running away or otherwise being absent from care, and to the extent possible and appropriate, responding to those factors in current and subsequent placements;

(iii) determining the child's experiences while absent from care, including screening the child to determine if the child is a possible sex trafficking victim (as defined in section 475(9)(A)); and

(iv) reporting such related information as required by the Secretary [of Health and Human Services]; and

(B) not later than 2 years after such date of enactment, for each child and youth described in paragraph (9)(C)(i)(I) of this subsection, the State agency shall report immediately, and in no case later than 24 hours after receiving, information on missing or abducted children or youth to the law enforcement authorities for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation, established pursuant to section 534 of title 28, United States Code, and to the National Center for Missing and Exploited Children.

The Missing Children Act of 1982 (see footnote 11) directed the U.S. Attorney General to keep records on missing children in the NCIC's Missing Persons File maintained by the FBI. This legislation also required the dissemination of records on missing children to State and local agencies.

ACF has issued implementing regulations for the Federal foster care program at 45 CFR parts 1355, 1356, and 1357. Provisions for receiving Federal reimbursement for the costs of the foster care program are codified in 45 CFR part 1356.

ACF GUIDANCE

ACF's Child Welfare Policy Manual, section 8.3B, Question 7, and ACF IM ACYF-CB/FYSB-IM-14-1 provide payment instructions directing that when a child who is Title IV-E-eligible is temporarily absent from a foster home, whether because the youth has run away or because of another circumstance (e.g., the youth is on a weekend home visit or is hospitalized for medical treatment), the State agency may provide a full month's Title IV-E foster care maintenance payment to the licensed foster care provider if the absence does not exceed 14 days and the child returns to the same provider.

ACF IM ACYF-CB-IM-14-03 provides basic information on the Strengthening Families Act, including Title IV-E plan changes, new case plan requirements and definitions, additions to the AFCARS, modifications to the Family Connection grants and John H. Chafee Foster Care Independence Program, and reauthorization of the Adoption and Guardianship Incentive Program.

ACF Program Instruction ACYF-CB-PI-15-07 provides instruction on the changes to the Title IV-E plan requirements as a result of the Strengthening Families Act that were effective as of September 29, 2015.

APPENDIX C: NUMBERS OF MISSING CHILDREN BY STATE[23]

State	Number of Children in Foster Care	Number of Missing Episodes	Percentage of Missing Children	Average Days Missing	Average Number of Times Missing	Missing Children as of 12/31/2020
Alabama	14,769	974	5%	62	1	117
Alaska	6,170	344	3%	96	2	29
Arizona	36,075	3,282	5%	54	2	277
Arkansas	11,962	482	2%	29	2	30
California	123,821	10,893	5%	41	2	2,767
Colorado	16,261	1,520	5%	53	2	63
Connecticut	16,316	5,062	5%	7	7	56
Delaware	1,503	239	7%	33	2	9
Florida	117,250	13,011	2%	10	5	156
Georgia	27,760	1,357	3%	46	2	137
Hawaii	4,447	274	3%	53	2	50
Idaho[*]	4,822	151	2%	N/A	2	N/A
Illinois	35,244	10,585	6%	12	5	178
Indiana	42,492	1,688	3%	34	2	84
Iowa	14,028	1,142	5%	34	2	65
Kansas	15,810	2,274	7%	27	2	89
Kentucky	23,580	1,703	5%	45	1	120
Louisiana	10,744	545	3%	32	2	17
Maine	4,486	112	1%	9	2	3
Maryland	9,480	1,044	7%	52	2	103
Massachusetts	26,676	3,350	5%	20	2	79
Michigan	24,177	1,855	5%	33	1	104
Minnesota	22,879	1,361	3%	34	2	64
Mississippi	10,576	499	3%	27	2	59
Missouri	29,569	1,780	4%	37	2	97
Montana[†]	3,315	288	5%	42	2	16
Nebraska	8,412	1,519	7%	16	3	36
Nevada	11,601	3,328	6%	18	5	44
New Hampshire	2,262	254	6%	14	2	2
New Jersey	12,151	350	2%	39	2	37
New Mexico[*]	4,595	367	4%	N/A	2	N/A

[23] We use "N/A" in some of the data fields in this appendix (and in some of the figures earlier in this report) to signify instances in which the data were either incomplete or not readily available from the State agencies. Further details appear in the reference marks beneath this table.

State	Number of Children in Foster Care	Number of Missing Episodes	Percentage of Missing Children	Average Days Missing	Average Number of Times Missing	Missing Children as of 12/31/2020
New York‡	15,431	5,354	7%	14	5	303
North Carolina	24,126	1,060	2%	31	2	90
North Dakota	3,837	151	2%	12	2	1
Ohio	41,639	8,065	7%	19	3	183
Oklahoma	18,901	840	2%	43	2	61
Oregon	14,912	1,502	5%	32	2	80
Pennsylvania**	N/A	1,287	N/A	N/A	N/A	N/A
Rhode Island††	N/A	N/A	N/A	N/A	N/A	N/A
South Carolina	12,455	509	4%	63	1	64
South Dakota	4,240	279	4%	27	2	14
Tennessee	24,331	2,168	6%	44	2	147
Texas‡‡	76,405	11,042	5%	21	3	432
Utah	6,852	858	5%	56	3	26
Vermont	11,500	38	0%	31	1	0
Virginia	14,722	948	3%	32	2	71
Washington	22,958	2,636	4%	23	3	80
West Virginia**	7,050	60	N/A	N/A	N/A	26
Wisconsin	20,313	1,992	3%	19	3	151
Wyoming	3,990	24	1%	54	1	2
Total	**1,016,895**	**110,446**				**6,619**

* Idaho and New Mexico did not provide all of the dates on which their missing children were located.

† Montana did not provide the names of its missing children because of State confidentiality laws. Additionally, each entry in the “Percentage of Missing Children” column is based on that State’s estimate of the total number of children in foster care between July 1, 2018, and December 31, 2020.

‡ New York gave us data only on missing children who were Title IV-E eligible; the other State agencies provided data for all missing children (that is, missing children who both were and were not covered by Title IV-E of the Act) in their custody.

** Pennsylvania and West Virginia did not provide data on all missing children episodes. Additionally, neither State provided all of the dates on which its missing children were located.

†† Rhode Island provided us with data that we could not use because they did not contain the information needed to do our analysis, including the dates on which missing children were located.

‡‡ Texas did not provide dates of birth for 614 (6 percent) of its 11,042 missing children episodes.

Meeting 4 – March 1, 2023

Materials

Runaway by Placement Setting Data

Colorado Department of Human Services

Runaway by Placement Setting

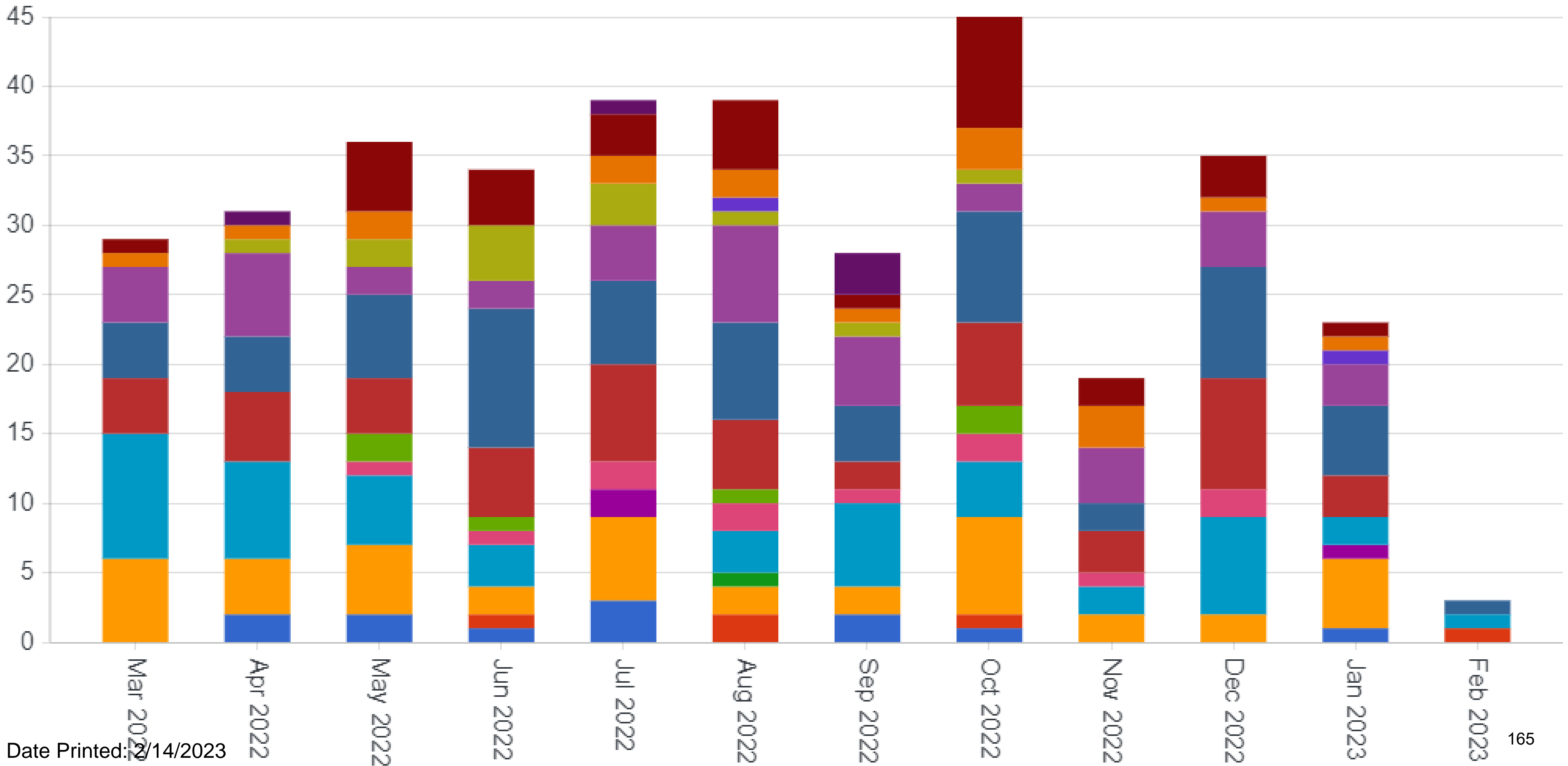
Type of placement that runaways ran from for runaways occurring during the report period. Data are current through Feb 10, 2023.

Time Period

Monthly | Mar 2022 - Feb 2023

Statewide

None



Time Period	Mar 2022		Apr 2022		May 2022		Jun 2022	
	Count	%	Count	%	Count	%	Count	%
Total Runaways	29	100 %	31	100 %	36	100 %	34	100 %
Runaways From Congregate Care	15	51.7 %	13	41.9 %	13	36.1 %	8	23.5 %
From Group Home	0	0 %	2	6.5 %	2	5.6 %	1	2.9 %
From PRTF	0	0 %	0	0 %	0	0 %	1	2.9 %
From QRTP	6	20.7 %	4	12.9 %	5	13.9 %	2	5.9 %
From Shelter Placement	0	0 %	0	0 %	0	0 %	0	0 %
From Other Psychiatric Hospital	0	0 %	0	0 %	0	0 %	0	0 %
From Other Residential	9	31 %	7	22.6 %	5	13.9 %	3	8.8 %
From DYS Secure Facility	0	0 %	0	0 %	1	2.8 %	1	2.9 %
Runaways From a Family-Like Setting	12	41.4 %	16	51.6 %	16	44.4 %	22	64.7 %
Runaways From a Foster Home Setting	12	41.4 %	15	48.4 %	14	38.9 %	18	52.9 %
From Kinship - Certified	0	0 %	0	0 %	2	5.6 %	1	2.9 %
From Kinship - Uncertified	4	13.8 %	5	16.1 %	4	11.1 %	5	14.7 %
From County Foster	4	13.8 %	4	12.9 %	6	16.7 %	10	29.4 %
From CPA Foster	4	13.8 %	6	19.4 %	2	5.6 %	2	5.9 %
From DYS Foster	0	0 %	0	0 %	0	0 %	0	0 %

Time Period	Mar 2022		Apr 2022		May 2022		Jun 2022	
	Count	%	Count	%	Count	%	Count	%
From Trial Home Visit	0	0 %	1	3.2 %	2	5.6 %	4	11.8 %
From Independent Living	0	0 %	0	0 %	0	0 %	0	0 %
From Runaway	1	3.4 %	1	3.2 %	2	5.6 %	0	0 %
Initial Runaway	1	3.4 %	0	0 %	5	13.9 %	4	11.8 %
From Other Placement Type	0	0 %	1	3.2 %	0	0 %	0	0 %
Date of Analysis	**Mar 2022**		**Apr 2022**		**May 2022**		**Jun 2022**	

Time Period	Jul 2022		Aug 2022		Sep 2022		Oct 2022	
	Count	%	Count	%	Count	%	Count	%
Total Runaways	39	100 %	39	100 %	28	100 %	45	100 %
Runaways From Congregate Care	13	33.3 %	10	25.6 %	11	39.3 %	15	33.3 %
From Group Home	3	7.7 %	0	0 %	2	7.1 %	1	2.2 %
From PRTF	0	0 %	2	5.1 %	0	0 %	1	2.2 %
From QRTP	6	15.4 %	2	5.1 %	2	7.1 %	7	15.6 %
From Shelter Placement	0	0 %	1	2.6 %	0	0 %	0	0 %
From Other Psychiatric Hospital	2	5.1 %	0	0 %	0	0 %	0	0 %
From Other Residential	0	0 %	3	7.7 %	6	21.4 %	4	8.9 %
From DYS Secure Facility	2	5.1 %	2	5.1 %	1	3.6 %	2	4.4 %
Runaways From a Family-Like Setting	20	51.3 %	21	53.8 %	12	42.9 %	19	42.2 %
Runaways From a Foster Home Setting	17	43.6 %	20	51.3 %	11	39.3 %	18	40 %
From Kinship - Certified	0	0 %	1	2.6 %	0	0 %	2	4.4 %
From Kinship - Uncertified	7	17.9 %	5	12.8 %	2	7.1 %	6	13.3 %
From County Foster	6	15.4 %	7	17.9 %	4	14.3 %	8	17.8 %
From CPA Foster	4	10.3 %	7	17.9 %	5	17.9 %	2	4.4 %
From DYS Foster	0	0 %	0	0 %	0	0 %	0	0 %

Time Period	Jul 2022		Aug 2022		Sep 2022		Oct 2022	
	Count	%	Count	%	Count	%	Count	%
From Trial Home Visit	3	7.7 %	1	2.6 %	1	3.6 %	1	2.2 %
From Independent Living	0	0 %	1	2.6 %	0	0 %	0	0 %
From Runaway	2	5.1 %	2	5.1 %	1	3.6 %	3	6.7 %
Initial Runaway	3	7.7 %	5	12.8 %	1	3.6 %	8	17.8 %
From Other Placement Type	1	2.6 %	0	0 %	3	10.7 %	0	0 %
Date of Analysis	**Jul 2022**		**Aug 2022**		**Sep 2022**		**Oct 2022**	

Time Period	Nov 2022		Dec 2022		Jan 2023		Feb 2023	
	Count	%	Count	%	Count	%	Count	%
Total Runaways	19	100 %	35	100 %	23	100 %	3	100 %
Runaways From Congregate Care	5	26.3 %	11	31.4 %	9	39.1 %	2	66.7 %
From Group Home	0	0 %	0	0 %	1	4.3 %	0	0 %
From PRTF	0	0 %	0	0 %	0	0 %	1	33.3 %
From QRTP	2	10.5 %	2	5.7 %	5	21.7 %	0	0 %
From Shelter Placement	0	0 %	0	0 %	0	0 %	0	0 %
From Other Psychiatric Hospital	0	0 %	0	0 %	1	4.3 %	0	0 %
From Other Residential	2	10.5 %	7	20 %	2	8.7 %	1	33.3 %
From DYS Secure Facility	1	5.3 %	2	5.7 %	0	0 %	0	0 %
Runaways From a Family-Like Setting	9	47.4 %	20	57.1 %	11	47.8 %	1	33.3 %
Runaways From a Foster Home Setting	9	47.4 %	20	57.1 %	11	47.8 %	1	33.3 %
From Kinship - Certified	0	0 %	0	0 %	0	0 %	0	0 %
From Kinship - Uncertified	3	15.8 %	8	22.9 %	3	13 %	0	0 %
From County Foster	2	10.5 %	8	22.9 %	5	21.7 %	1	33.3 %
From CPA Foster	4	21.1 %	4	11.4 %	3	13 %	0	0 %
From DYS Foster	0	0 %	0	0 %	0	0 %	0	0 %

Time Period	Nov 2022		Dec 2022		Jan 2023		Feb 2023	
	Count	%	Count	%	Count	%	Count	%
From Trial Home Visit	0	0 %	0	0 %	0	0 %	0	0 %
From Independent Living	0	0 %	0	0 %	1	4.3 %	0	0 %
From Runaway	3	15.8 %	1	2.9 %	1	4.3 %	0	0 %
Initial Runaway	2	10.5 %	3	8.6 %	1	4.3 %	0	0 %
From Other Placement Type	0	0 %	0	0 %	0	0 %	0	0 %
Date of Analysis	**Nov 2022**		**Dec 2022**		**Jan 2023**		**Feb 2023**	

Time Period	Mar 2022 - Feb 2023	
	Count	%
Total Runaways	361	100 %
Runaways From Congregate Care	125	34.6 %
From Group Home	12	3.3 %
From PRTF	5	1.4 %
From QRTP	43	11.9 %
From Shelter Placement	1	0.3 %
From Other Psychiatric Hospital	3	0.8 %
From Other Residential	49	13.6 %
From DYS Secure Facility	12	3.3 %
Runaways From a Family-Like Setting	179	49.6 %
Runaways From a Foster Home Setting	166	46 %
From Kinship - Certified	6	1.7 %
From Kinship - Uncertified	52	14.4 %
From County Foster	65	18 %
From CPA Foster	43	11.9 %
From DYS Foster	0	0 %

Time Period	Mar 2022 - Feb 2023	
	Count	%
From Trial Home Visit	13	3.6 %
From Independent Living	2	0.6 %
From Runaway	17	4.7 %
Initial Runaway	33	9.1 %
From Other Placement Type	5	1.4 %
Date of Analysis	Mar 2022 - Feb 2023	

Meeting 4 – March 1, 2023

Presentation

Review of Laws & Data Requirements

Office of the Colorado Child Protection Ombudsman

YOUTH WHO RUN FROM THEIR OUT-OF-HOME PLACEMENT

A Review of Laws and Data Requirements

Child Protection Ombudsman
Stephanie Villafuerte

March 1, 2023

Responding To Youth Who Run from Out-of-Home Placements

*A review of **Federal law** that guides the response to youth who run from out-of-home placement.*

FEDERAL LAW

Locating and Ensuring Safety of Missing Youth

Title IV-E (42 U.S.C. § 671(35) requires States to develop and implement specific protocols, including:

- Expeditiously locating missing foster youth
- Determining factors that contributed to the youth's running away, and if possible, responding to those factors in current and subsequent placements
- Determining the youth's experiences while absent from care, including screening for sex trafficking
- Reporting to law enforcement authorities immediately, and in no case later than 24 hours, after receiving information on a missing or abducted youth

Responding To Youth Who Run from Out-of-Home Placements

*A review of **Colorado laws and regulations** that guide the response to youth who run from out-of-home placement.*

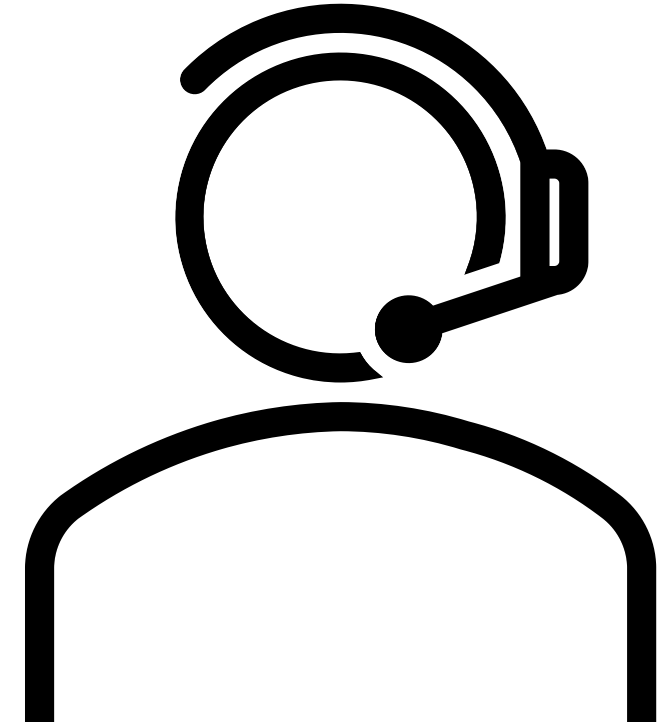
STATE LAW AND REGULATIONS

Reporting Missing Youth to LE

C.R.S. § 19-1-115.3 and CO Code of Regs. Tit. 12, § 2509-4 (7.303.4)* establishes reporting requirements for **human service departments** with legal custody of a youth.

It requires departments to report immediately, and in no case later than 24 hours, to the National Center for Missing and Exploited Children (NCMEC) and to law enforcement after learning of the disappearance of a youth.

C.R.S. § 16-2.7-103 (2)(b)(II)(Missing Persons Response)
Upon notification law enforcement will notify CBI within 2 hours and enter any relevant information into the CCI database.



*Human Trafficking Regulation

Runaways-Duty to Notify

C.R.S. § 19-2.5-1508 and CO Code of Regs. Tit. 12, § 2509-4 (7.303.4)* establishes reporting requirements for ***foster parents and out-of-home placement facilities***.

When juveniles who are detained, committed to the department of human services, or otherwise sentenced or placed in out of home placements pursuant to 19-2.5-1103, runs away from a facility or home in which they are placed, the person in charge of the facility or foster family must notify the court and local LE as soon *as possible after discovering the juvenile has runaway.*

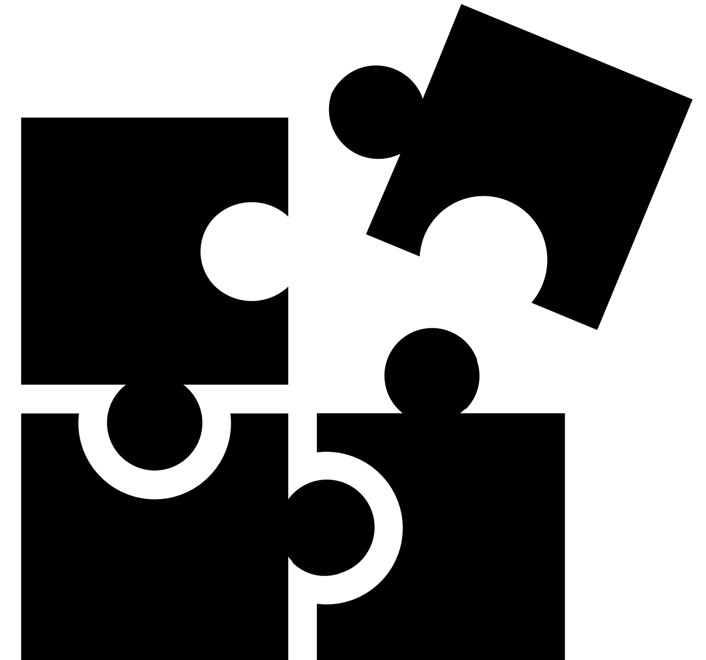
*Human Trafficking Regulation

STATE LAW AND REGULATIONS

Determining Factors for the Run

CO Code of Regs. Tit. 12, § 2509-4 (7.303.4)* requires county departments, upon the return of the youth, to make reasonable efforts to determine the primary factors that contributed to the child being missing and document those efforts in the State automated case management system.

* Human Trafficking Regulation



STATE LAW AND REGULATIONS

Determining Placement Suitability

CO Code of Regs. Tit. 12, § 2509-4 (7.303.4)* requires county departments, upon return of the youth, to make reasonable efforts to respond to the factors that contributed to the child being missing by addressing the issues in current and subsequent services.

*Human Trafficking Regulation

STATE LAW AND REGULATIONS

Assessing Experiences

CO Code of Regs. Tit. 12, § 2509-4 (7.303.4) requires county departments, upon return of the youth, to make reasonable efforts to determine the child's experiences while missing, including conducting a sex trafficking screen to determine if the child is a possible sex trafficking victim.

STATE LAW AND REGULATIONS

Gaps in State Law and Regulations

- No timeframes for closing a child's placement after running away.
- No duty to locate youth/only report
- Regulations address sex trafficking context; not other circumstances
- Difficulties accessing data (TRAILS)

Questions?

Stephanie Villafuerte, Child Protection Ombudsman

svillafuerte@coloradocpo.org

Meeting 4 – March 1, 2023

Presentation

Runaway Rules & Data

Colorado Department of Human Services

CDHS Division of Child Welfare
Runaway Rules & Data

Laurie Burney & Jessica Starr
Division of Child Welfare

Timothy Montoya Task Force
03/01/2023

COLORADO
Department of Human Services

Volume 7 Rules on Runaway

- Volume 7, or Social Services Rules in the Colorado Code of Regulations, contains rules pertaining both to counties and to providers regarding children and youth who enter runaway status.
  - Important to look at both sets of rules to have a comprehensive picture of responsibilities and reporting.
  - Volume 7 located here
- In addition, the federal government also requires states to report on children and youth in out-of-home placement that enter runaway status.
  - AFCARS (Adoption and Foster Care Analysis and Reporting System) requires that states track runaway spans for children and youth in out of home (OOH) care.
  - This is accomplished in Colorado in that if a child or youth runs away from their placement, that placement is end-dated and an new runaway authorization is opened.
  - Publicly available ROM data here

Volume 7: Provider Rules

- 7.708.52B (12 CCR 2509-8)
  - The foster care home shall notify the parent(s), guardian(s), or placing authority as soon as possible upon discovery that a foster child has run away.
- 7.714.933B (12 CCR 2509-8)
  - The facility shall notify the legal custodian, and/or placing authority as soon as possible upon discovery that as child has run away.
- 7.701.52A (12 CCR 2509-8) Critical Incident Reporting for 24-hour agencies, facilities, and day treatment centers:
  - Within twenty four (24) hours, excluding weekends and holidays, of the occurrence of a critical incident at the facility or within twenty four (24) hours of a child's return to the facility: (5f) Report if a child/youth leaves without consent if under the age of 18 and does not return to the facility or foster home within 24 hours.
    - This rule definition was derived from the Runaway/Walkaway Group that involved Department staff, counties, and providers in 2013 and 2014.

Volume 7: County Rules

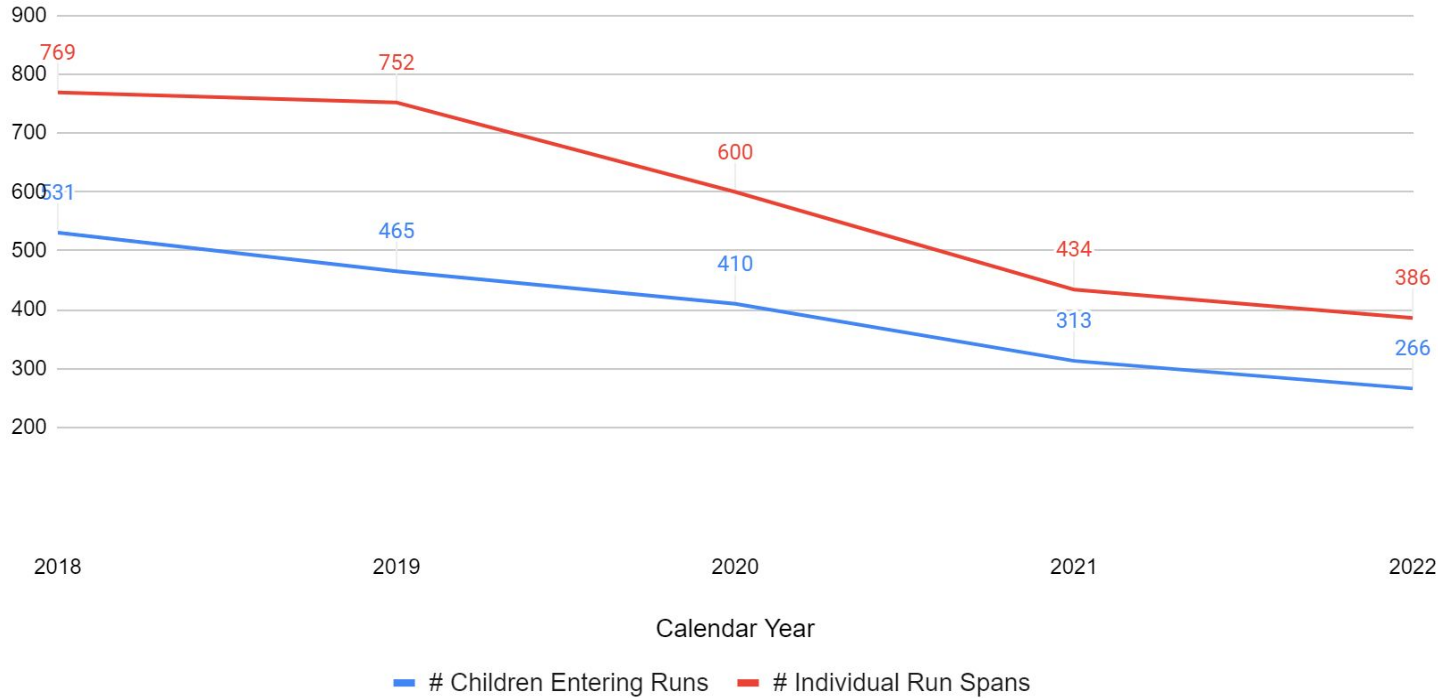
- 7.304.53G (12 CCR 2509-4)
    - The county department shall notify the court of jurisdiction and other parties within 10 calendar days of receipt of a report that a child has run away from placement.
- 7.303.4(B) (12 CCR 2509-4)
    - If a child/youth who is in the legal custody of the county department of human or social services is missing then the county departments shall:

        1. Report immediately and no later than twenty-four (24) hours from when the county department receives notification that the child/youth is missing, to the local law enforcement agency and to the National Center for Missing and Exploited Children (NCMEC). The county department shall document the details of the reports in the state automated case management system.
        2. Make reasonable efforts to locate a child/youth who is missing and document those efforts a minimum of once per month in the state automated case management system:
        3. Upon the return of the child/youth, make reasonable efforts to complete the following activities and document those efforts in the state automated case management system:

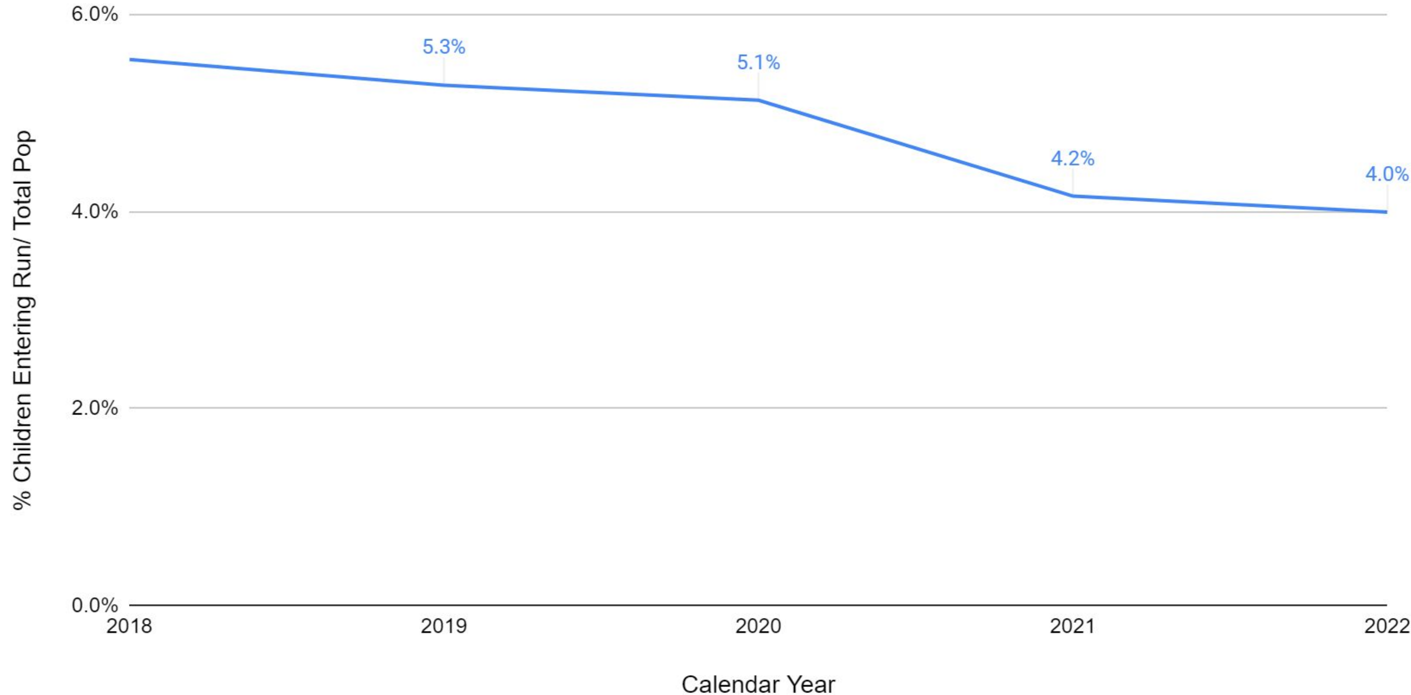
            a. Determine the primary factors that contributed to the child/youth being missing;
            b. Determine the child/youth's experiences while missing, including conducting sex trafficking screen to determine if the child/youth is a possible sex trafficking victim; and,
            c. Respond to factors identified in 3, A and B, above, in current and subsequent services.

Current Data

Data retrieved from Trails, ROM 02/06/2023, Child Welfare-only



Data retrieved from Trails, ROM 02/06/2023, Child Welfare-only



Since 2018 the total number of children and youth in out-of-home placement during a given year has dropped from 9,600 to 6,700 (Foster Care Counts, Foster Care Count during Period)

Data retrieved from Trails, ROM 02/06/2023, Child Welfare-only

Questions and Answers

Presenter Contacts:

Laurie Burney- Laurie.Burney@state.co.us

Jessica Starr- Jessica.Starr@state.co.us

COLORADO Department of Human Services

Meeting 4 – March 1, 2023

Minutes

POLICY COLLABORATIVE FOR CHILDREN & FAMILIES

KEYSTONE POLICY CENTER

Timothy Montoya Task Force | Meeting Four

March 1, 2023, Meeting Minutes

Recording

March 1st, 2023, 8:00 am-11:00 am Virtual Meeting (Zoom)

Facilitator: Trace Faust

<table>
<tr><td>Welcome & Approval of Minutes</td><td>After member welcome, Task Force Chair Stephanie Villafuerte approved minutes from the September 28, 2022, November 2, 2022, and January 3rd, 2023 meetings. Present members approved the minutes as drafted.</td></tr>
<tr><td>Summary of prior meetings</td><td>Task Force Chair Stephanie Villafuerte shared her gratitude to Task Force members who participated in one-on-one conversations held during the previous weeks. These conversations were powerful and added nuance to the larger group discussion. Jennifer Superka, Office of Colorado's Child Protection Ombudsman, named the prospective barriers time may present to the Task Force and suggested the Task Force consider additional standing meetings during the off month with breakout options. Members were supportive of the additional meetings and submitted their conflicts via the chat function. Jennifer provided a summary of previous meetings and also reviewed the meeting's agenda and goals.</td></tr>
<tr><td>Defining Runaway Missing from Care</td><td>Jennifer Superka and Trace Faust, Keystone Policy Center, share a definition for the term, "runaway". The term "runaway" was presented as "used with respect to a youth, means an individual who is less than 18 years of age and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian." This definition for some can imply the responsibility is on a child for their own care and can obscure factors of why youth go missing from care. Trace Faust highlights this is rooted in asset-based language and without this distinction, information is missing that could be helpful in preventing and treating missing youth. The term "missing from care" was proposed in Richard's and Branscum's presentation, and included in taskforce materials. Trace Faust requested members to provide feedback on the terms "runaway" and "missing from care.

The group discussed the following:
Some members expressed that "runaway" is sufficient as the responsibility is on the child or youth due to their decision-making process, despite the outcome.
Those members explained that a child or youth is determined to be a "runaway" based on intent and evidence. If the evidence</td></tr>
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	displays the child or youth was taken, law enforcement would act as if it was a kidnapping incident. If the evidence displays the child or youth left on their own accord, law enforcement would act as if it was a runaway incident. There is a focus on choice and intent. ● A few members stated that the term "runaway" allows blame to be placed on the child or youth. Children or youth have no choice in their out-of-home placement options and can not contact family freely. Some members disagree that all youth leaving facilities or homes are bad actors as there are so many variables and things beyond the youth's control. ● Members stated that the term "runaway" does create a barrier with outreach as it holds a negative connotation. They also shared that running is not a crime. ● A member shared that they felt "runaway" is the correct term and Task Force members are falsely applying a negative connotation to the term. ● Trace Faust added that children and youth are a vulnerable population and there is the ability to have both terms exist within the Task Force. ● A few members suggested the term "elopement" could serve as an alternative and assert there should be separate terms. ● Some members feel a common definition would be helpful as multiple departments and agencies have various terminology for runaway. ● A suggested solution is to use the term "runaway" bolded to accurately express the various reasons why youth may be running/missing from care. This would be beneficial and would allow the work of the Task Force to be seen as more reputable
Reporting Requirements	Task Force Chair Stephanie Villafuerte provided Task Force members with a review of federal law that currently guides the response to children or youth who run from out-of-home placement. This review included federal law regarding the protocols for locating and ensuring the safety of missing youth, as well as Colorado laws and regulations for reporting missing youth to law enforcement. She also presented requirements for foster parents and out-of-home placement facilities. Additionally, Stephanie Villafuerte highlighted state regulations on determining factors to run, determining placement suitability and effectively assessing the experiences of youth who run. Members share their questions or comments on the information presented: ● It is valuable for members to keep in mind there is nothing left to do when the case has closed. ● Specialized Alternatives for Families and Youth (SAFY) is currently piloting an AWOL assessment for youth to try and understand the root of running;it may be beneficial to the group to consider. ● Are payroll rules dependent on Volume 7? ● There may be a competing commitment for child welfare professionals in entering a runaway placement status, due to the inability to pay a placement to hold the bed for seven days at the same time. Often, the

	runaway status isn't entered until that time or at all if the youth or child returns to care. It would be beneficial if there was a way in Trails to show a "runaway" status while still paying the placement to keep the bed. This is especially true when there is a lack of placements.
Data Presentation	Trace Faust grounds members in the first legislative charge of the Task Force, which is to analyze the sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placement. Members listen to a presentation by Jessica Starr of the Colorado Department of Human Services' Division of Child Welfare, and Laurie Burney, Provider Performance Manager, of the Colorado Department of Human Services (CDHS). The presentation included Volume 7 rules on "runaways", providers and counties as well as supporting data. The data presented included "runaway" critical incidents by calendar year, total children entering "runaway" status, number of unique runs and percentage of children and youth who run from out-of-home placement. Additionally, data shows the number of youth in out-of-home placement has decreased from 9,600 to 6,700 children. Members share their questions or comments on the information and data presented: ● A member inquired about the difficulty of changing a regulation ○ Laurie Burney shared, in her experience, it is a years-long process that requires approval by the State Board of Human Services and must be supported by robust research. ● A member asked if there is data that displays youth with a history of running and abruptly stopping? This may allow the Task Force to discover what is the most effective tool to persuade youth to stop running. ○ Jessica Starr referred to the data set displaying the number of children or youth entering "runaway" status and the number of unique runs as valuable to review. The Trails system does have a notes section to add important information on the child or youth, though it is not easily accessible. ● A member asked what outside effects have impacted this data including the Family First Act? ○ Jessica Starr shares that Family First Act and other programs have impacted placement data, but COVID-19 is the largest variable in the data. ● A member asked if there is a mandate on contacting youth after running? ○ Laurie Burney shares there is only a monthly contact requirement.This can be done by phone or video chat. ● What is the definition of out-of-home placement used in the data? ○ Jessica Starr shared that if the youth is in county custody, they are deemed as an out-of-home placement.

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A member asked if it would be helpful if the reporting mechanism included a N/A selection option as members often select "no" when not enough information is available, thereby altering the data set.
Jessica Starr shares gratitude for this comment and will consider it moving forward.
Members discussed how correlation is not causation, fewer runs are attributable to Family First Act. It is just as likely fewer runs are more attributable to fewer beds.
As the Task Force continues to be more purposeful and intentional about placement, members should continue to see a decrease in children leaving without permission.

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<tr><td>Break Out Groups and Debrief</td><td>
Trace Faust invited members to break out into smaller groups to discuss the data presented through the lens of the first legislative charge.

Members were asked to consider the following questions:

What does the data presented tell us about the experience of children who run away from placement?
What data is missing for the task force to understand the experience of children who go missing from care?
Additional comments and questions.

Members entered their thoughts into a google document and verbally shared them back to the larger group. Highlights shared from the breakout groups include:

Group 2, represented by Brian Cotter, shared a desire for additional data, specifically, data that displays why youth are running and data that equitably quantifies volume to be actionable. Group 2 would value a time-based analysis and a more robust dive into TRAILS data fields.
Group 3, represented by Lynette Overmeyer, shared disappointment with the data as presented and would appreciate more nuanced data that intersects with topics like running history and substance use. There should be an additional requirement to report when a youth runs.
Trace Faust stated that if the data required isn't available, it would be important to include that in the Task Force's reports.
Group 4, represented by Co-Chair Beth McNally, shared similar sentiments as Groups 2 and 3 and highlighted Group 4 is aware placement is dependent on availability, but is interested in what has worked in other areas with similar circumstances.
Group 1, represented by Jenna Coleman, shared a desire to see data separated by county and by placement.
Trace Faust thanked members for their participation in the breakout groups and for providing their feedback. Chair Stephanie Villafuerte reinforced this and thanked members for having a robust conversation

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	on data and what it means. She additionally asks a question back to the Task Force to consider based on break-out group conversations: Does data matter? Would it behoove the Task Force to focus on prevention rather than data of current standing?
Public Comment	Trace Faust opened the discussion for public comment. ● Kristin Myers, Ph.D. Assistant Professor of Counselor Education and Supervision (Core) shares with Task Force members that she is currently conducting focus groups for youth 18-22 that are currently in treatment facilities who have a history of running to share their reasons for running. This is rich data that may be beneficial to the Task Force.
Next Steps and Adjourn	Trace Faust highlights the next steps of the Task Force will include a follow-up email with a calendar invite for the off-month meetings and creating a monthly meeting schedule. Chair Stephanie Villafuerte adjourned the meeting at 10:54 am

Meeting 4 – March 1, 2023

Recap

Timothy Montoya Task Force | Meeting Four

March 1, 2023, Meeting Recap

Overview

The Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement is legislatively charged with analyzing the root causes of why children and youth run from out-of-home placement to help develop a consistent, prompt and effective response to responding to children and youth who run from care. It is also charged with assessing how to address the safety and well-being of children and youth upon their return to care.

Summary of Marcy 1, 2023, Meeting

Directive Discussed: *Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))*

Examining the Use of the Term "Runaway"

Members discussed the term "runaway" and its connotations. The group focused on understanding the reasons why youth leave care, but also acknowledges that youth may not always have a choice in leaving. They will do further exploration and engage in more discussions to find a more suitable term and agreed that this conversation is essential in defining and understanding the problem.

Overview of Federal and State Laws Regarding Youth Who Run Away

Stephanie Villafuert provided an overview of federal and state laws and regulations that determine reporting requirements and protocols when youth run from out of home placement. These requirements determine the data that is collected and reported about these incidents.

Stephanie discussed the importance of federal law in dictating state laws and regulations related to youth who run away and child welfare. The federal law requires states to develop and implement specific protocols for dealing with missing youth, such as immediately reporting and locating missing youth, as well as determining the factors that contributed to them running away and their experiences while absent from care.

Certain provisions of Title 19 of the Colorado Revised Statutes (Children's Code) and Volume 7 of the Colorado Code of Regulations (Social Services Rules Staff Manual Volume 7; Child

Welfare, Child Care Facilities) guide the response to youth who run away from out of home care. Stephanie provided the group with a list of the applicable statutes and regulations.

Some of the challenges and gaps in state law and regulations were highlighted:

- Caseworkers document all required information about a child's experience, why they ran from care, etc., in the Trails database, but it is not easily extractable because it is in narrative form. This creates an impediment to identifying patterns and making prevention efforts.
- Lack of guidance from state law and regulations on when human service cases can be closed. While some jurisdictions keep these cases open for up to a year, there have been reports of cases being closed sooner, which could result in the loss of valuable data to assess the experiences of children who run away from care. This lack of guidance on when to close cases poses a challenge to understanding the patterns of children running away and their experiences. Lynette Overmeyer clarified that although there is no rule on how long a placement stays open for a runaway youth, there is a payroll rule that only allows payment for placement for seven days when the youth is not present. Current regulations and laws related to runaway children primarily focus on anti-trafficking efforts. This creates a lack of information on other experiences that may lead to a child running away, such as exposure to criminal activity or behavioral health disorders. The rules and regulations are broad, leaving it up to caseworkers to ask the right questions and find the best solutions for the youth. However, there is a need for more distinct guidance and regulations to address the various reasons a child may run away.
- There is no duty to locate youth who run away, only to report.

Norma Aguilar-Dave explained that funding streams for providers do not allow them to look for children who have left their homes. For example, if a child who was receiving in-home services through Medicaid leaves their home, the provider has to close the case immediately. They cannot continue working with the parents to identify the child's whereabouts or prepare for the child's return. This is because there is no provision in the funding streams that would allow providers to do so.

Colorado Department of Human Services Data Presentation

Jessica Starr manages the data unit at the Colorado Department of Human Services' (CDHS) Division of Child Welfare, overseeing data collection and analysis for 64 County departments. Laurie Burney, the Provider Performance Manager, works with Dennis Desparios at CDHS to license and monitor all providers offering services and out-of-home

care, including residential providers, child placement agencies, day treatment facilities, and adoption agencies in Colorado.

Laurie provided a brief overview of Volume 7 and highlighted the fact that foster parents and facilities are also required to notify parents or guardians as soon as possible when a child runs away. She also highlighted the distinction between a runaway and a walk away is based on the amount of time the youth is gone. A runaway is defined as a youth who is gone for more than 24 hours, while a walk away is a youth who walks outside the facility for a break, but does not leave for more than 24 hours.

She provided a link to Volume 7 Rules and to Publicly Available ROM Data.

Jessica presented the data collected by CDHS. The data presented focused on critical incidents of runaways reported by licensed providers in the child welfare system from 2018 to 2022. Jessica noted that there was a significant increase in reporting from 2018 to 2019 due to new reporting requirements, but from 2019 to 2022, there has been a steady decline in runaway incidents reported. The decline may be attributed to factors such as policies that were the result of the Family First Prevention Services Act (Family First) implementation, trauma-informed care plans and the impacts of COVID-19.

Jessica presented data on the following:

- The number of incidents of children and youth running away from care
- Total children and youth entering "runaway status" and total unique run spans
- Percentage of children and youth entering "runaway status of the out-of-home population"

Questions from task force members included:

Brandon Miller asked about data tracking for traditional or system runaways and their reasons for stopping running from one provider to another. He mentioned that there is an assumption that providers are less successful because 95% of the children and youth in their facility have a history of running away from care. He also suggested collecting data on children and youth within the Division of Youth Services (DYS) system since they are often at higher risk. Jessica agreed and recommended bringing in someone from the DYS data team to clarify any differences in their data.

Janelle Goodrich questioned the decrease in runaways and placements after the Family First was implemented, acknowledging the possibility of other factors at play and data that may not be captured in the system. She pointed out the impact of the COVID-19 pandemic and advocated for a longer evaluation period to accurately assess the act's impact.

Beth McNalley asked two questions:

1. Is there a mandate on a time frame when a caseworker contacts the youth upon their return?

   Answer: There is no specific mandate, but the minimum requirement is to have at least monthly in-person contact with the youth.

2. Is there a set mandate on training for using the HRV tool, and have there been any efforts to expand the tool's capabilities to allow for more detailed responses?

   Answer: There is no set mandate on training for using the HRV tool, and the level of detail in responses can vary depending on who is filling out the tool. Some systems force responders to give a simple yes or no answer, even if more detail is necessary. There has been discussion about potentially expanding the tool's capabilities in the future to allow for more detailed responses.

Jessica asked about capturing deeper information such as demographic data and a youth's experience while they were on the run. The Trails system has a child welfare side that contains demographic and placement information, but capturing a youth's experience can be challenging. Notes may contain this information, but text searching can give false results.

Laurie said that her team will follow up with a clear summary of the data fields that CDHS can and has filled out. Then, they will create an internal list of other potential sources of data. She also mentioned that they are collaborating with outside research institutions to gather more information on lived experiences.

Small Group Discussion of Data Presented

Link to Note Catcher:
https://www.dropbox.com/s/cus25m5dy2lguuy/Note%20Catcher%20_%203.1.pdf?dl=0

The groups provided summaries of their discussions:

- The current data on runaway children only quantifies volume and is not actionable.
- Several questions were not answered by the data, including information about a youth's experience while they are on the run, making it difficult to address the issue.
- Want to compare the volume of children in placement who run away to those who are not in placement.

- The current data did not distinguish between the types of placement, abuse, neglect, or other factors that could be analyzed.
- Need for a check-the-box analysis of the Trails database and a detailed time-limited study of every child that runs away within a certain window to gather more information.
- Lack of a statewide system for gathering uniform information or a standard tool for youth when they return from a run.
- Importance of gathering information from providers when the youth leave.
- Barriers to locking facilities and the effectiveness of trauma-informed care.
- Importance of intentional placement and location of youth, as well as establishing a plan from the start.
- Value of hearing from the youth directly and considering the effectiveness of phone check-ins versus face-to-face meetings.
- Tracking what works for caseworkers in locating youth and implementing it as training.
- Importance of sharing information between partner organizations, specifically human services departments and law enforcement.
- Importance of having data broken down by county and facility to identify themes and patterns.

Stephanie raised a point from her discussion group: how much does the data matter? Kevin Lash talked about how if we could just prevent runaway behavior in the first place, it would allow us to get to the why by making sure that kids are getting the treatment and services they need.

Meeting 5 – April 12, 2023

Agenda

KEYSTONE
POLICY CENTER

Timothy Montoya Task Force Meeting
Agenda

April 12, 2023 | 8 a.m. to 10 a.m.

Virtual – Zoom (Zoom Link available **HERE**)

Facilitators: Keystone Policy Center

Trace Faust

Time	Agenda Topic	Facilitator / Presenter
8:00 a.m. to 8:10 a.m.	**Welcome and Review** ● Member Roll Call ● Brief Review of March 1, 2023, Meeting	Trace Faust and Stephanie Villafuerte (Chair)
8:10 a.m. to 9:05 a.m.	**Defining or Replacing the Term "Runaway"** ● Members will resume the discussion about using an alternative phrase for "runaway" or defining the term for use within Task Force discussions and reports. ○ ***Review of March 1, 2023, Discussion*** (For convenience, all of the materials discussed during the previous meeting are provided below.) ■ Task Force Discussion ● Members may review the discussion held during the previous meeting by accessing the video recording below. ○ Click **HERE** to watch a video recording of the discussion. (Timestamp: 18:45 to 37:25)	Trace Faust

9:05 a.m. to 9:55 a.m.	**Sufficiency of Quantitative Data** ● Directive: ○ Is current statewide, quantitative data regarding the experiences of children who have run away from out-of-home placements sufficient? (See C.R.S. 19-3.3-111(5)(a))	Trace Faust

	• Members will resume the discussion about whether current statewide, quantitative is sufficient to serve children and youth who run away from out-of-home placements. The group will conclude this discussion and any possible recommendations. ○ ***Review of March 1, 2023, Discussion*** (For convenience, all of the materials discussed during the previous meeting are provided below.) ■ Current Colorado Law • Materials from Stephanie Villafuerte's presentation on current statutory requirements for reporting when a child runs away from out-of-home placement are provided below. ○ Click **HERE** to watch a video recording of the presentation and discussion. (Timestamp: 37:45 to 1:02:19) ○ Click **HERE** to review the PowerPoint presentation. ■ Current Data Collection • Materials from the Colorado Department of Human Services' presentation on current data collection and analysis are provided below. ○ Click **HERE** to watch a video recording of the presentation and discussion.(Timestamp : 1:02:46 to 1:57:56) ○ Click **HERE** to review the PowerPoint presentation.	
9:55 a.m. to 10:00 a.m.	**Closing Remarks**	Trace Faust and Stephanie Villafuerte

Meeting 5 – April 12, 2023

Minutes

Timothy Montoya Task Force | Meeting Five

April 12, 2023, Meeting Minutes

Recording

April 12th, 2023, 8:00 am-10:00 am Virtual Meeting (Zoom)

Facilitators: Trace Faust and Doris Tolliver

Members: See Appendix A

Welcome	Trace Faust and Chair Stephanie Villafuerte welcomed members to the meeting.
Introduction to Doris Tolliver	Trace Faust introduced Doris Tolliver to The Timothy Montoya Task Force as a co-facilitator who will be joining the team permanently. Doris Tolliver is a strategic thinker specializing in racial and ethnic equity, organizational effectiveness, change management and business strategy development. She has spent her career working to advance the interests of vulnerable populations, serving in programmatic and leadership roles in both the private and public sectors. Members may learn more about Doris Tolliver at this link.
Alternative Phrase For "Runaway"	Trace Faust asked members to resume the discussion about using an alternative phrase for "runaway" or defining the term for use within Task Force discussions and reports. The initial discussion of alternative phrasing occurred during the March 1st, 2023, meeting and can be referenced through member materials. Trace Faust also highlighted previous presentations given to the Task Force by the University of Nebraska and underscored that children and youth are a vulnerable population.The alternative phrase, if the Task Force chooses, can include sub-definitions for clarity. Task Force Chair Stephanie Villafuerte spotlighted how language and stigmatization can affect care to youth and that youth who run are often additionally vulnerable due to abuse, neglect, substance abuse, mental health concerns and overall trauma accrued during their lifetime. (All comments are individual and not attributed to the Task Force.) Members were asked to share their individual thoughts: ● A member shared that, statistically, 1 in 3 youth on the run is approached by a trafficker within 48 hours. ● Some members stated that language is important and should define the choice of the youth. They elaborated that: ○ Kidnapped/Missing youth requires a different protocol by law enforcement and other responding parties, compared to the term

	"runaway." Youth that chooses to run should share some accountability for their decision in spite of external factors. Additional members agreed with this sentiment. ○ A member highlights how terms have changed to reflect present social opinions like " victim and survivor." ○ Regardless of the language the Task Force selects, at the end of the day the response to elopement needs to reflect a high-risk behavior by the youth.. ● Members shared that bias or stigmatization with "runaways" may be a common struggle amongst service providers as it lends to the thought process that a child or youth that runs is defiant. ● Other members stated that different kids leave for different reasons and the approach should be responsive to those individual situations. Members took an informal "thumbs up, thumbs down" poll and broadly agreed to use person-first language moving forward with the example "a child who has run from care" instead of the term "runaway"
Sufficiency of Quantitative Data Directive:	Doris Tolliver asked members to discuss if current quantitative data is sufficient regarding the experiences of children who have run away from out-of-home placements. This was intended to be a breakout group discussion but due to technical difficulties, members were asked to share their thoughts to the full group. (All comments are individual and not attributed to the Task Force.) ● The HRV tool is going to be revamped. ○ *Point of information: The Colorado High-Risk Victim (HRV) Youth Identification Tool is intended to be used as a supplement to comprehensive screenings, assessments, or intakes that explore a multitude of life domains. The HRV Youth Tool should be utilized to improve upon identification of potential victims of exploitative abuse, and not as a validated diagnostic tool.* ● A member asks a question regarding hearsay around a spike in runaway youth since the Family First Act passed and whether the Colorado Department of Human (CDHS) services is able to address that increase. ○ * Point of information:The Family First Prevention Services Act (Family First) is a federal law that allows local child welfare agencies to use federal funding to pay for services that keep kids safe, growing up in their families. ● Members discussed whether data shows youth placed in facilities by family members, compared to child welfare departments. Such data would be very helpful however, it doesn't fix the lack of placements to help these youth. ● Members discussed whether there is data available regarding environmental factors that impact youth the most and lean towards running. ● Members discussed whether data is kept within the narrative section of Trails would be beneficial for this Task Force, as it can detail a fuller picture of a youth's running history and may inform why they run.

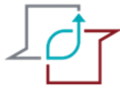
	○ A possible recommendation is that the Trails system is extended to include youth, caseworker and provider point of views. ● Children and youth have the 'right' to be kept safe. Members discussed the need to empower providers to set and enforce boundaries ● As a Task Force, members discussed the need to understand the problem through data to know what extent of action is needed. When asked if current quantitative data is sufficient regarding the experiences of children who have run away from out-of-home placements members present voted in the chat. Of the present members, all but one voted no. There was one abstention by Dennis Desparrois. Chair Stephanie Villafuerte thanks Timothy Montoya Task Force members for a robust and enriching discussion.
Public Comment	There was no public comment give.
Next Steps and Adjourn	Trace Faust shared their gratitude to members. Chair Stephanie Villafuerte adjourned the meeting at 10:54 am

Appendix A:

Kelly Abbott
Norma Aguilar-Dave
Ashley Chase
Anna Cole
Jenna Coleman
Brian Cotter
Dennis Desparrois
Jenelle Goodrich
Chelsea Hill
Kevin Lash
David E. Lee
Dr. Renée Marquardt
Beth McNalley
Brandon Miller
Becky Miller Updike
Elizabeth Montoya
Lynette Overmeyer
Stephanie Villafuerte
Jana Zinser

Meeting 5 – April 12, 2023

Recap



Timothy Montoya Task Force | Meeting Five

April 12, 2023, Meeting Recap

Overview

The Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement is legislatively charged with analyzing the root causes of why children and youth run from out-of-home placement to help develop a consistent, prompt and effective response to responding to children and youth who run from care. It is also charged with assessing how to address the safety and well-being of children and youth upon their return to care.

Summary of April 12, 2023, Meeting

Directive Discussed: *Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))*

Use of the Term "Runaway"

The intention of the discussion was not to change use of the term within existing systems, as the discussion is not a directive included in statute. However, the group sought to define the language used by the group and in the Task Force's reports. In addition to being brought up by multiple task force members, presenters from the University of Nebraska highlighted issues with data on youth who run from out-of-home placement that does not differentiate such incidents from the myriad of reasons youth leave care. One suggested replacement term for runaway is "children missing from care." Trace Faust, with Keystone Policy Group, found that the larger context and language used by national organizations is around a child being "vulnerable and missing" -- regardless of the reason why they went missing. Research emphasized the importance of understanding the vulnerability of missing children and treating them equally, regardless of the reason for their absence.

Points brought up in the group discussion included:

Negative Stereotypes

Using the word "runaway" when referring to children leaving care reinforces negative stereotypes about these children, portraying them as troublesome or bad children. These misconceptions make it difficult for the community to deter these kids from running away or relocating them. The stigma associated with the word "runaway" can

cause people to assume that the child does not want treatment. This can also affect how law enforcement responds to the situation.

Dr. Renée Marquardt agreed and pointed out that terms are neutral until stigma gets attached, so using a new term may take on its own bias as well without efforts to change the stigma itself.

Understanding Why a Child Left Care

Lynette Ovemyer shared a recent situation in Mesa County where a 9-year-old boy with autism was labeled a "chronic runaway" by law enforcement, implying that he has control over his behaviors. Lynette suggests that the label of "runaway" limits our understanding of the complexity of the situation.

Brandon Miller brought up the issue of two types of runaways in out of home placements: one where the child or youth is in an irrational state of mind and crisis, and their reaction is more of a walk away or exit rather than a premeditated attempt to run away; the other where the child premeditated a run. The solutions for these two types of runaways are different and should not be lumped into one category.

Focus on Specific Set of Children

The phrase "runaway" is appropriate because it helps to focus efforts on understanding the child's experience and finding ways to help them stay in placement. The phrase does not diminish the child's vulnerability or the risks they face while missing.

Need for Education and Training

Janelle Goodrich suggested that instead of changing the terminology, statewide training and education on language should be provided to officers who respond to runaway calls in order to provide them with preventative strategies, without making assumptions or negative judgments about the child or youth.

Brian Cotter emphasized that the group should be specific in its recommendation on training and education to address the preconceptions of law enforcement responding to runaway events.

Conclusion

Based on the discussion, the group decided on a middle ground regarding person-first language and will use language that prioritizes the child as an individual, for example, "a child who has run away." This approach will be reflected in the report and the group's discussions.

Sufficiency of Quantitative Statewide Data

Doris introduced the second part of the meeting, addressing the group's first legislative directive to assess the sufficiency of statewide data that measures the quantitative experiences of children who have run away from out-of-home placement.

Among the ideas brought up by the group were:

- Collecting quantitative data on a county and facility level so that data could be compared to see what works and doesn't. Collecting qualitative data on tools and interventions used by facilities could complement the quantitative data and help to spread effective practices.
- Collecting baseline data is crucial.
- Collect data on how long children are gone and where they go when they leave.
- Differentiating between kids in child welfare custody versus those in family custody to understand the differences in experiences and reasons for running away.
- Gathering data on why children or youth are running is important for prevention and developing protocols to keep them safe and get them to come back.
- Extracting missing youth data from the Trails database system and reporting it in a more understandable and accessible format is necessary to utilize the data. (Versus extracting data from a narrative form.)
- Creating a "missing from care" page in Trails would be a useful addition to gather useful data for in-depth research on runaways.
- Conducting chart reviews and data collection from various sites could provide necessary information to develop effective interventions for different groups of children in foster care.
- It is important to act quickly to develop interventions and improve data collection, rather than waiting for data systems to be built.
- The potential impact of the Family First Act on the number of runaways was discussed, and it was suggested that further research is needed to determine whether there has been an increase in runaways since its implementation.
- Acknowledging different types of placements have different needs and challenges, making it difficult to come up with a one-size-fits-all solution.

Lynette offered another solution to address one of the limitations of the current data system. She suggested obtaining more accurate information about the number and duration of runaway episodes of children who are missing from care through Trails by creating a category for the run bed hold, which would create the ability to differentiate between paying for the bed and an actual missing episode. This would enable helpt to asses the actual

duration of runaway episodes. (Now, child welfare can only pay for a bed for up to seven days and cannot change the status to runaway in Trails until after that time.)

Task Force Determination

> Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient?

The majority of the members present stated that the current quantitative data is not sufficient.

Meeting 6 – May 3, 2023

Agenda

Agenda - Timothy Montoya Task Force | Meeting Five

May 3, 2023 | 8am-11am

Virtual - Zoom

Facilitators: Trace Faust and Doris Tolliver

Time	Agenda Topic	Facilitator Presenter

8:00 a.m. to 8:10 a.m.	**Welcome and Review**
	• Member Roll Call
	• Approval of Meeting Minutes
	  ◦ March 1, 2023
	  ◦ April 12, 2023
	• Meeting Recaps
	  ◦ March 1, 2023,
	  ◦ April 12, 2023
		Trace Faust and Stephanie Villafuerte (Chair)

8:10 a.m. to 8:25 a.m.	**Task Force Progress and Charter** • Review of the Work Todate • Presentation of the Task Force Charter	Trace Faust
8:25 a.m. to 8:35 a.m.	**Where We're Going** • Roadmap for 2023	Trace Faust and Doris Tolliver
8:35 a.m. to 9:35 a.m.	**Qualitative Data** • Directive for Discussion ◦ Members will focus discussion on the following directive: Is current statewide, qualitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))	Trace Faust, Doris Tolliver and Dr. Kristin Myers

	• Presentation of Focus Group Report ◦ Dr. Kristin Myers, with the University of Denver's Colorado Evaluation & Action Lab, will present the report: Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements. This report was commissioned pursuant to C.R.S. 19-3.3-111(6)(a), which required the CPO to contract with an institution of higher education to, conduct focus groups with children and youth in out-of-home placements, as well as providers,to "determine what conditions lead children to run away from out-of-home placement, the provider's efforts to locate children who have run away, and the services provide to a runaway child upon the child's return." The full report may be accessed by clicking HERE. • Q & A Session	
9:35 a.m. to 9:45 a.m.	**BREAK**	
9:45 a.m. to 10:30 a.m.	**Breakout Group Discussion** • Members will move into breakout groups to discuss the directive, as well as the report and findings presented by Dr. Myers.	Full Group
10:30 a.m. to 10:45 a.m.	**Large Group Discussion** • Members will return to the full group and present their group's discussion and key points.	Trace Faust and Doris Tolliver

10:45 a.m. to 10:55 a.m.	**Public Comment**	Trace Faust
10:55 a.m. to 11:00 a.m.	**Closing Remarks**	Trace Faust and Stephanie Villafuerte

Zoom Information

Topic: Timothy Montoya Task Force
Time: May 3, 2023 08:00 AM Mountain Time (US and Canada)

Join Zoom Meeting
https://us02web.zoom.us/j/87394706137?pwd=bURIcnh5dFRZM2EwTDY1RmtjNUNPQT09

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+1 564 217 2000 US
+1 646 558 8656 US (New York)
Meeting ID: 873 9470 6137
Passcode: 301853
Find your local number: https://us02web.zoom.us/u/kkqbQd72H

Meeting 6 – May 3, 2023

Materials

Youth & Provider Perspectives Study

DU Action Lab

Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements

AUTHORS:

Kristin Myers, PhD, LPC, SSP
Congress Park Counseling and Consulting

Lexi Wimmer, MA, LPC, LAC
Doctoral Candidate, University of Northern Colorado

Kristin Klopfenstein, PhD
Director, Colorado Evaluation and Action Lab

REPORT HIGHLIGHTS:

- Connectedness is run prevention, intervention, and aftercare.
- Youth run *from* out-of-home placements when they become dysregulated to try to get their needs met. They run *to* connectedness and familiarity.
- Youth have a predisposition to test boundaries and desire autonomy over their own lives. Opportunities for both are limited in out-of-home placements, so running can reflect these typical adolescent needs.
- Providers must follow prescribed protocols when a youth runs and overall feel they do not have the autonomy to locate a youth who has run from a placement.
- The degree of connectedness youth feel with providers has an impact on their ability to psychologically and physically regulate after returning from a run.
- Programmatic and systemic barriers make it difficult to prevent a run from occurring.

For inquiries contact: Kristin Klopfenstein| kristin@coloradolab.org | www.ColoradoLab.org

Report Number: 23-05A. Date: April 1, 2023

Abstract

In the 2022 legislative session, lawmakers passed House Bill 22-1375 Concerning Measures to Improve the Outcomes for Those Placed in Out-Of-Home Placement. This statute required the Office of Colorado's Child Protection Ombudsman to enter into an agreement with an institution of higher education to examine the issue of youth running away from out-of-home placements from a lived experience perspective. This report contains the results of five focus groups, two with out-of-home placement providers, and three with youth ages 12-17 currently residing in out-of-home placement. Providers and youth provided their perspectives on (1) What conditions led to running from an out-of-home placement? (2) What efforts were made to locate a child or youth after a running incident? (3) What services were provided to the child or youth after a running incident? and (4) What programmatic and systemic barriers make it difficult to prevent a run from occurring? In addition to the questions required by statute, the results also provide insight into what happens right before a running incident, the impact of childhood trauma on running behaviors, a lived experience perspective on prevention efforts, and the importance of connectedness for youth in out-of-home placements.

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Acknowledgements

This research was supported by the Office of Colorado's Child Protection Ombudsman. The opinions expressed are those of the authors and do not represent the views of the State of Colorado, Congress Park Counseling and Consulting, the Office of Colorado's Child Protection Ombudsman, or the University of Denver. Policy and budget recommendations do not represent the budget or legislative agendas of state agencies, the Governor's Office, or other partners.

Thank you to our partners who provided subject matter expertise and guidance on this project: the Office of Colorado's Child Protection Ombudsman, the Colorado Association of Family and Children's Agencies, and the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placements. Thank you to the out-of-home placement providers and their staff for their time in participating in the focus groups and arranging for focus groups with youth participants. We would like to express deep gratitude to the youth in out-of-home placements for providing their perspectives and for sharing their lived experiences on this topic.

Data Sources

Data was collected through conducting five focus groups. Thank you to the Office of Colorado's Child Protection Ombudsman, the Colorado Association of Family and Children's Agencies, and the Timothy Montoya Task Force for assisting in finding focus group participants.

Suggested Citation

Myers, K., Wimmer, L., & Klopfenstein, K. (April 2023). *Strengthening connections: Youth and provider perspectives on youth running from out-of-home placements* (Report No. 23-05A). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver.

Note on Language Regarding "Runaway"

The Timothy Montoya Task Force is working to develop common language that accurately reflects a child or youth's experience on the topic of "runaway." For the purposes of this report, language from House Bill 22-1375 will be used to ensure required elements of the bill were fulfilled.

Introduction

Timothy Montoya was a 12-year-old residing in an out-of-home placement who was tragically hit and killed by a car in 2020 while on the run from an out-of-home placement. His death highlighted statewide concerns about the lack of consistent, prompt and effective responses to youth who run from out-of-home placements. In 2022, House Bill (HB) 22-1375 Concerning Measures to Improve the Outcomes for Those Placed in Out-of-Home Placement Facilities was passed in Timothy Montoya's honor.

Timothy Montoya's life ended tragically as a result of running from an out-of-home placement. Running from out-of-home placements is a common occurrence resulting in potentially dangerous situations such as being a victim of crime, injury, or death. The Office of Colorado's Child Protection Ombudsman and professionals in the child protection field assert that Colorado is in a mental health state of emergency. The rise in children and youth mental health concerns in Colorado has caused concern for out-of-home treatment facilities, parents, child welfare agencies, and legislators. Stakeholders like these see a need for statewide quality assurance and accountability systems, and supports for children with runaway behaviors. Such tools are valuable for promoting quality services for high-needs children. With such tools in place, caregivers can feel assured that their child's placement will be safe. Concerned stakeholders also value the importance of amplifying child and youth voices to enhance understanding of runaway behaviors.

> *"Not all kids run away because they're necessarily bad kids or because they want to make bad decisions, but sometimes it's because they don't know what to do and they're looking for help. ...it's not necessarily because they're bad or that they want to make bad decisions but because they... trauma. They are looking for something, they're looking for a way to get their needs met, and don't know how to get those needs met. So, they're trying whatever way they know how rather than trying a healthy, more positive manner."*
>
> **- Youth Focus Group Participant**

The purpose of HB 22-1375 is to establish the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placements, which began in September 2022 and will meet for two years. One of the requirements of the Task Force is to analyze root causes of why children run away from placement in order to develop a consistent, prompt, and effective response for children who run away from placement and will also address the safety and well-being of children upon return to placement after a run.

Additionally, HB 22-1375 required the Office of Colorado's Child Protection Ombudsman to enter into an agreement with an institution of higher education with experience in child welfare research to conduct focus groups with providers and youth in out-of-home placements to better understand the lived experience on this topic. The statute specifically requires the researcher to conduct focus groups with children and youth who have experienced out-of-home placement. The five focus groups were conducted in early 2023 across Colorado, and this report highlights the findings. Providers and youth provided their perspectives on (1) What conditions led to running from an out-of-home placement? (2) What efforts were made to locate a child or youth after a running incident? (3) What services were provided to the child or youth after a running incident? and (4) What programmatic and systemic barriers make it difficult to prevent a run from occurring? In addition to the questions required by statute, the results also provide insight into what happens right before a running incident, the impact of childhood trauma on running behaviors, a lived experience perspective on prevention efforts, and the importance of connectedness for youth in out-of-home placements.

Project Rationale and Description

Project Rationale

Children and youth who reside in residential treatment facilities often face significant behavioral health needs and are provided with critically important services to meet their complex needs in their out-of-home placements. Running away from out-of-home placements such as residential treatment facilities is common.[1] While there are a variety of reasons a child may run from out-home-placement, running is a coping behavior. Prior research indicates children are either running to (access), or running from (avoidance of someone or something).[2, 3, 4] Running away can adversely affect children and youth in a multitude of negative ways including criminal victimization, sexual exploitation, physical and mental health problems, homelessness, and delinquent behavior.[5, 6, 7, 8] The most severe risk to children and youth who run away is the risk of dying from intentional or accidental means.[9]

Prior research indicates children and youth in group placements are more likely to run away from care than those in family placements.[10, 11, 12] Children with more than two placements and a higher number of separation incidents from their homes have a significantly higher risk of running from an out-of-home placement.[13, 14] Prior research has established a range of individual risk factors that increase the risk of running incidents with children in out-of-home placement such as child's age (teens in particular), gender, race, substance use, and mental health history.[15]

The research regarding why children run from treatment facilities is predominantly quantitative and does not capture the lived experience of children and youth who run from out-of-home placements. To date, there is one qualitative study, which was conducted in 2005.[16] Courtney et al. (2005) interviewed 42 children who had run away between 1993 and 2003. The children were asked why they ran, which led to the finding that they were running to something or from something. The study also concluded that running behavior was related to four broad categories: (1) running to family of origin, (2) returning to friends and/or the streets, (3) maintaining relationships with friends or extended family members, and (4) running spontaneously.

While the study was groundbreaking, it also contains several notable limitations. It is dated, did not include information regarding the services provided to children and youth before a running incident, and did not include information about what happened to them once they were returned to care. This report addresses these gaps and also provides the perspectives of service providers. Findings from this project are consistent with previous research (e.g., reasons for running and where youth go while on the run).

Project Description

This project provides critical data to inform the Task Force on the following primary questions related to youth who run from out-of-home placements:

1. **What conditions led to running from an out-of-home placement?**
2. **What efforts were made to locate a child or youth after a running incident?**
3. **What services were provided to the child or youth after a running incident?**
4. **What programmatic and systemic barriers make it difficult to prevent youth from running from an out-of-home placement?**

In addition to the questions required by statute, the results also provide insight into what happens right before a running incident, the impact of childhood trauma on running behaviors, a lived experience perspective on prevention efforts, and the importance of connectedness for youth in out-of-home placements.

Methods

Purpose of Qualitative Research Perspectives

The primary investigator (PI) used qualitative research methods to capture the lived experiences of children and youth as well as out-of-home services providers on the issue of youth running from out-of-home placements. Although public policies have a direct impact on the lives of children, youth, and service providers who experience running behaviors, their voices are rarely included in research.[17, 18] Recent research has explored individual and societal factors that influence running behavior; however, the *voices* of the children and youth who reside in facilities and the providers who serve them have rarely been explored.

The data collected in this project establishes critical context for policy and practice recommendations. The narratives of the children and youth provide first-hand knowledge of what it is like to experience an out-of-home placement and the impact running incidents have on the child who runs as well as their peers. The service providers' lived experience provides a comprehensive description of how they perceive running behaviors as well as the impact the run has on the individual child and facility as a whole. Amplifying youth and provider voices provides stakeholders and policymakers the opportunity to gain more understanding, empathy, and awareness.

Sample

A purposeful criterion-based sampling strategy was used to seek participants who are experts on the experiences of children and youth who run from out-of-home placement. The Office of Colorado's Child Protection Ombudsman, the Colorado Association of Family and Children's Agencies, and members of the Timothy Montoya Task Force provided a list of potential focus group participants, including children and youth up to age 22 and out-of-home placement providers.

Actual children and youth participants ranged in age from 12 to 17. The invitation to participate included children and youth up to 22 years of age; however, there was not representation in this project for children under age 12 or youth 18 to 22. While including voices of all ages would have been ideal, the ages in this sample are consistent with previous research that indicates adolescents ages 13 and over are most likely to run from placements.[19] The participants had the ability to communicate verbally and the capacity to recount their experiences with running incidents in out-of-home placement programs. Youth focus group participants represented three out-of-home placement providers located in northern, front range, and southern Colorado.

Out-of-home service provider focus group participants represented facilities located in northern, Front Range, southeast, and southern Colorado. The focus groups included a variety of service roles within the facility including directors, supervisors, and direct care staff.

Focus Group Protocol

A semi-structured interview protocol was developed to facilitate a rich and robust description of experiences from the participants' perspectives. This included 12 guiding questions for the youth and the providers that were directed toward the main purposes of the study and evaluation questions (see Appendix A). The focus group facilitator reflected participant experiences throughout the focus groups to check for accuracy of what was being said.

In qualitative research, data collection typically ends when saturation is reached, which means no new information is emerging. In this project, saturation was reached after two provider focus groups and three focus groups with children and youth.[20] The focus groups were audio-recorded and transcribed into written form to ensure accuracy of participant quotes. The transcripts were used to code the data into overarching themes. In addition to the PI, two independent qualitative research coders each reviewed transcripts and codes to ensure accuracy of the PI's initial findings.

Key Findings

Each section contains a summary of the narrative provided by the youth and provider focus groups. Direct quotes from the youth participants are in **green** and provider quotes are in **brown**. Appendix B provides additional direct quotes for each topic.

The PI began each focus group by asking youth questions from the semi-structured interview protocol about running. In each group youth asked, "you mean AWOLing?" The term AWOL was widely used as common terminology among youth to describe running incidents and behaviors. This term was used regardless of the out-of-home placement during the interviews.

Findings are organized according to each of the four primary questions.

1. What conditions led to running from an out-of-home placement?

> **Focus group participants indicated three conditions that led youth to run from their out-of-home placement.**
>
> - **Running from the placement due to dysregulation from triggering events, disconnection from staff, and responses to previous trauma.**
> - **Running to connectedness and familiarity.**
> - **Running due to typical adolescent behavior.**

Conditions that Led to a Run: Running *From*

Triggering events, disconnection with staff, and responses to previous trauma

Consistent with previous literature, provider and youth described instances where youth ran *from* a situation for a variety of reasons. Regardless of the reason for running from an out-of-home placement, children are typically dysregulated at the time of a run. Youth focus group participants describe being in a state of emergency, often described as "fight, flight, or freeze", and are unable to access the parts of their brain that allows them to make rational decisions an understand consequences. Therefore, youth who are dysregulated are more likely to run from an out-of-home placement.

Dysregulated youth may experience physical symptoms such as increased heart rate, irregular breathing patterns, or the inability to think or perform simple tasks. Common reasoning is not available to youth in this state of functioning. They cannot think of consequences or foresee their actions as potentially dangerous. [21, 22] The youth and provider focus group participants described events that led up to the child dysregulating. Although youth and providers may view these situations differently, the same three underlying themes emerged about what makes a child at risk for dysregulation and therefore to running from an out-of-home placement: triggering events, disconnection with staff, and responses to previous trauma.

Triggering Events

Children in out-of-home placements have individualized treatment plans. These plans frequently change and that results in a change in the child's daily life and expectations for the future (e.g., longer time in out-of-home placement, change in placement, or a change in their child welfare case). This can result in dysregulation and a potential running incident. Providers and youth had two different perceptions: youth who run after a phone call or visit from an external care provider like a caseworker or parole officer, and/or running after a phone call or visit from their family. Youth also indicated they ran, or thought more about running, after visiting family on a pass home.

Calls and visits from a member of their external provider team can result in a change in the child's treatment trajectory or out-of-home placement plan. Providers cited these conversations as events that can trigger a youth running from placement. Provider participants also referred to incidents where a child was regulated until they received a phone call from their family. The call could be regarding something the youth is missing out on with their family while in the out-of-home placement, or an argument with a family member.

> "In a lot of the cases, kids have to be alone to make phone calls with their professional. In a delinquency filing, an attorney will want to talk and want to do it alone. If they get bad news there, that's one of the ways. When we get it right, we're engaged, the programs engaged in the call. The stage is set nicely and we're able to work with and through it, but when we don't know, you know, a lot of times this is what happens."

A Disconnection with Staff

Youth participants described feeling disconnected, unseen, or unheard as a reason for running from an out-of-home placement. Youth and providers also noted staff shortages prevent youth from getting what they need from staff. Youth participants often described themselves and their peers as "attention seeking" when they were not getting their psychological or physiological needs met due to a lack of staff time. Youth participants also described feeling unsafe or disconnected with some staff members based on their experiences in the placement.

> "One reason why people like AWOL is because like, it's just, you don't want to be in the situation you're in. And, like, sometimes, especially here, it gets really stressful with the staff and youth. Staff do a lot of stuff that makes, like, that makes us want to, like, not talk or not speak around people. And it's just like, sometimes it's hard to open up the staff or open up to youth because you don't know what's going on, or you don't know who you're with, like, you know. You don't really want to be here. It's just more or less, you want to have a – you don't want to, like, spend the time here because, like, it's just really hard."

> "In our facility, we would want to say that all of our staff are doing the right things. Sometimes, that wasn't the case. Sometimes, kids walked away because they didn't feel like staff were as caring as they should have been or were not able to provide the space that they needed; it's a myriad of things."

Youth participants noted times where they did not feel respected or understood by staff and ran as a means of removing themselves from that situation. Some youth recalled instances where they felt unsafe with staff and ran in order to protect their safety. Whether or not staff agree with this assessment is immaterial to the youth who is perceiving danger as a reality in their worldview. Providers noted the youth are often working through extensive treatment plans, which can be difficult to explore and running is a means of protecting their psychological safety.

> "I was thinking about AWOLing was because I was uncomfortable with the male night staff. He was just being very, very inappropriate. I wanted to leave so that he would not continue to be inappropriate. I wanted to AWOL because let's see, a grown man, and a teenage girl, who has already been through that situation, it made me extremely uncomfortable there."

> "I also think a really common reason or issue is that we are forcing them to talk about really difficult things and to confront some unhealthy behaviors and patterns, and that's really difficult to do even as an adult. So, try to sometimes – their first reaction is, "This is too hard. I don't want to do it," and then their thought is to run."

Responses to Previous Trauma

Youth in out-of-home placements often have a history of complex trauma, and they are viewing their world and interactions within the world from that lens.[23] Humans have a desire to connect with others,[24] and the perception of connection can be skewed and informed by a youth's past, particularly if they experienced childhood trauma.[25, 26, 27] In addition to running, trauma responses can include self-harming behaviors as a means of coping with an event that made them recall trauma.[28, 29, 30] Participants noted that youth were not necessarily aware of why they were running, and some youth were running as a way of asking for help. When a response to past trauma puts children and youth into a state of dysregulation, it increases the likelihood of a running incident.

> "Not all kids run away because they're necessarily bad kids or because they want to make bad decisions, but sometimes it's because they don't know what to do and they're looking for help. The only way they can find that help is by running away and going, whether that be to a friend's house or running away and calling the police or – I wish I didn't have to do that, but running away and to another family member, and even running from a facility, it's not necessarily because they're bad or that they want to make bad decisions but because they…trauma. They are looking for something, they're looking for a way to get their needs met, and don't know how to get those needs met. So, they're trying whatever way they know how rather than trying a healthy, more positive manner."

> "Sometimes kids will talk about engaging in risky or unsafe behavior, such as running away, because they need support. They don't know how to ask for it other than physically acting out or saying that they're going to because they know that if they say they're going to do something unsafe or something risky, that they'll get that additional support. That's how they ask for it because they don't know how to go up to somebody and be like, "Hey, I'm struggling. Can you help me with this?" …that's where a lot of the disconnect is, is because they don't have the mental capacity to

> understand that sometimes they can ask for it and we'll provide it, rather than putting themselves in an unsafe situation to get the support that they need."

Trauma and the dysregulation that occurs as a result makes it difficult for youth to anticipate the danger they are in when they physically leave their placements and are out in the community, or sometimes, in harsh elements of nature. Providers were widely concerned about the high risk of trafficking, other victimization by adults, self-harming behaviors, serious injury, or death while on a run. In short, the adults understand and the youth may not have the ability to foresee risk for a variety of reasons. Youth participants spoke to events that occurred on a run in a matter-of-fact manner while recounting their experiences, while providers spoke with a clear sense of concern.

Provider and youth participants described times in which they were regulated, having a typical day/night, and seemingly acted on impulse in running. Youth and provider participants did not recall a particular event that led to a run in some instances. In other examples, youth noted boredom as a factor. Part of this may be due to typical adolescent brain development, but the risks that come from a running incident are the same regardless of the reason.

> "Normally before someone goes AWOL, they just say they're going to AWOL and then they just go. This all just builds up."

> "They are bored. If you're bored of the program, then like there's – why would you think of staying?"

> "I think [what] plays a part for our youth is just simply impulsivity. They are all emotionally dysregulated, and they kind of can turn on a dime. The first thing that they do is look to get out of whatever situation they are in, and so that oftentimes ends up being translated into some type of high-risk behavior. The getting away is leaving wherever you are currently, and then, if people are following you, you keep going, basically, and so then it ends up kind of going on and on and has a snowball effect. I think it starts with the fact that they're all emotionally dysregulated, which kind of lends itself to the high level of impulsivity."

> "That was really tough from a provider standpoint, to have to watch and know that they could cross the perimeter and five minutes later, "Oh, let me come back," and we have to call in authorities, but we saw a lot of dysregulation. For me, it became this whole thing about adolescent boys' brain development, that they were not thinking, and then you add the trauma, and you add all of the other stuff on top of it, they did not have the wherewithal to make a good decision at that point, in my opinion, having to be able to stop and regulate and then make a choice, right? I didn't feel like they used brain development and/or the trauma-informed stuff when we talk about walkaways, and we talk about where they're at physically and emotionally and socially."

> "Not that long ago, we had an incident where we had two youths that ended up going off campus together and finding just the smallest piece of glass, and they lacerated themselves from ankles to head. Then, they took their blood and were sharing it with the other person inside the other person's wounds, and no idea what each kid had available to them or if they were diagnosed with anything, and then were sharing that dangerousness with each other and that they were feeding off of each other. When we brought them back, they were covered head to toe in blood, and just were having the greatest time of their lives and laughing, did not feel suicidal at all, but they just were so engaged in this dangerous behavior and this impulsivity that they didn't even see what they were doing was dangerous to themselves."

"We also operate a facility up in [a location of an interstate]. There is a huge truck stop, so that is a huge…it's a huge concern. We've got both boys and girls up there, and so the trafficking, it's a huge concern, so you have every right to be fearful of having another access point for those kids and for perpetrators."

"If they go to [a local store], they can find somebody that will give them a ride to wherever it is they want to go, some random person to put them in their car, and they don't even realize the danger that they're putting themselves in, that somebody could actively be looking for some kid like that to take and do whatever it is that they want with them. They don't even realize that they could disappear, that anything could happen to them, and every time that they get brought back to the facility, because, luckily, they have been brought back, we have these conversations and they're like, 'Oh, I didn't even think about that,' or, 'Nothing would have happened to me.' They're so nonchalant, and so disconnected from the reality of what it is that could happen to them getting in a stranger's vehicle."

"With it being [a city] and being the hub for child trafficking, I think that has a lot to do with it too. Unfortunately, the sad fact is that some of these kids are the providers for their families while trafficking for like parents that aren't working or can't work. And they feel like that if they don't run and provide for that family that the family is going to struggle. The lack of services, I guess, for other family members in a way is causing that running to happen."

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

Youth in out-of-home placements are not currently residing with their family of origin and are often unable to connect with friends and peers in person during their placement. Youth participants describe making phone calls and receiving visits from family, but are still desiring more connectedness to their loved ones and friends. Youth reported they are often limited to 10 minutes per day for phone calls and sporadic visits from families. Many youth participants recall phone calls from an approved list or visits with family that results in them missing being home and triggering a desire to return home. Youth also indicated a sense of missing out as a result of being physically away from their closest connections. In these instances, youth report running to an environment that includes their family, friends, or others they care about. Youth also described a desire to connect to familiar environments or places. Youth reported on times they felt homesick, felt as if they were missing out on important events with family and friends, were missing friendships and interactions with peers at home, and the desire to be and feel connected. Providers also spoke to interacting with youth who are missing family connectedness.

"I honestly just didn't want to sit here and do another six months of treatment. And in my head, that just felt like I'm trying so hard to become, trying so hard to go home and be like a person that I want to be. It's really hard because a lot of us, me, we, have so many people at home that we care about. For my specific situation, I have two little sisters, and I'm missing my little sister's first days of kindergarten, and she's getting bullied in school right now. And I have to hear about it over a phone. It really sucks. So, I guess I just wanted to leave, that's pretty much why I ran."

> "When we said kids that have been in the system for a while, you know, they don't feel like all of the entities that are involved in their life have really worked hard to keep family connection, keep them involved with family. But I think we see them, you know, get more hopeless and they want to run to their family or they want to feel that connection with family."

> "I was running to something but I was also running away from something. Whether that be abuse, sadness, whether it's physical or not physical, I was always just trying to run away from something. What I was running to was helping me get away from whatever I was running from, whether that be someone's house or drugs or whatever it may be. It could even be food, to be completely honest. It was just always something that I was chasing that helped me get away from what I was running away from."

Providers and youth also noted substances as a precipitating factor in the desire to run. Whether they were experiencing symptoms of withdrawal, craving a substance, or they obtained substances while on the run, this was a prevalent theme across youth and provider participants. Engaging in substance use can increase other risk-taking behaviors as well as the potential for victimization.

> "Sometimes the programs are restricting the things that they really want to do. Because they just – from what I'm thinking of, they experience withdrawals, so then they think the only way that they can get what they need, what they think they need is to leave the facility and get access."

> "People run just [to] get their drugs. Just straight up drugs."

> "Particularly, I mean a substance-using youth. They'll start having those cravings and we'll start seeing some more of that behavior, that craving behavior beforehand and really try and mitigate that, but that's a tough task to overcome and the kids really struggle with craving. Once in a while we see situations where kids just kind of blow up and they'll be super aggressive and explosive and they'll just take off."

Conditions that Led to a Run: Running as Typical Adolescent Behavior

Developmentally, youth have a predisposition to test boundaries, explore the world around them, and form their own friendships and bonds. Several youth participants describe behaviors and instances any typically developing adolescent may experience. Additionally, as with any human, youth desire access to rights and autonomy over their own lives. These are not necessarily readily accessible to youth in an out-of-home placement.

> "When I was first here, I was AWOLing because I just want to be a butt, and I know a lot of kids that just AWOL just do it. I know those people, and you can decipher those people. I was one of those people."

> "I think some kids that have been in congregate care for a while and have been in multiple placements sometimes know that there really isn't much consequence to running and they can go have fun for a couple of hours or overnight or go to some party and then come back, and there's not any real meaningful consequence. So, they just kind of do it to – almost like a joyride. Go take some time for themselves."

As with any typically-developing adolescent, they do not necessarily have an adult view of potential consequences and life-threatening outcomes of these behaviors. While typical, the behaviors are not always safe or without the potential for severe consequences. Whether a youth is running from or running to something, or simply acting in a way that is developmentally appropriate for an adolescent, running from out-of-home placement has the potential for dire consequences. As discussed in previous sections, this could be due to a trauma response, or it could be a part of a typically developing brain.

> "They like, hitchhike. They like to talk with people that, "Can I get a ride? Can I get a ride?" They'll go like further from the facility because the facility is like, so many people know about it."

Typical adolescent development also includes a sense of rights, autonomy, and justice in one's life. Youth in out-of-home placements inherently experience restriction over these human needs.

> "I will run because there's no way out. I'm not an adult yet. I'm still a minor, and there's nothing in my power that I can do to. You know? Hear my voice."

> "Leaving the facility, or walking out, or running is the only way I feel like I can say something, or I can make myself heard."

> "The first time I AWOL-ed—the only time I AWOL-ed— is because I was getting refused a phone call and my personal items. My needs aren't getting met. I feel like I had to run away to get heard. Also, like I felt like dealing with stuff I was dealing with at home was happening here. They were considering our family supports, our 10-minute phone calls, that we only get once a day, to be a privilege. Those are my support systems."

Conditions that Led to a Run: Summary

The focus groups were asked about the conditions that lead children to run away from out-of-home placements and their responses included much more than conditions. The youth and provider responses to this question also spoke in depth about *why* children and youth run from out-of-home placements. Most of the results in this section were consistent with previous literature on the topic; however, the participants also provided more context for what it is like for someone who has experienced trauma and the impact the symptoms of trauma as well as typical brain development has on running behavior. The providers in this section also discussed the importance of understanding brain development, trauma, and other mitigating factors of mental illness can have on the youth's ability to foresee or understand consequences of their actions. Participants also provided context for the importance of human connection and relationships. Whether running from, to, or running as typical behavior, youth had a strong desire to avoid connections they deemed unsafe and find places where they feel connected. The importance of connectedness appears throughout this report with respect to prevention, intervention, and after care.

2. What efforts were made to locate a child or youth after a running incident?

> **Providers indicated they must follow a prescribed protocol when a child runs, and overall felt they do not have the autonomy to locate a child once they run from the facility.**

Providers spoke to the protocols in place to report a youth who ran from a facility as well as the responsibility and worry they feel for youth who are on the run. Providers indicated they must follow a prescribed protocol when a child runs, and overall felt they do not have the autonomy to locate a child once

they run from the facility. Provider participants indicated major changes after C.R.S. § 26-20-102(6) took effect regarding restraining youth in out-of-home placement facilities. The law restricts providers' use of restraints to situations where children or youth are in imminent danger to themselves or others. This can leave providers feeling that their only option when a child runs is to report the child missing to law enforcement.

The provider participants also discussed the strategies they take to keep youth in their line of sight for as long as possible while trying to convince them to return to their placement. At the same time, some of the providers worried about losing their job or license if these strategies were perceived as inappropriate by state agencies or in defiance of protocols within their own organization. Lastly, providers noted their concern for youth well-being and going home worrying about youth who were on the run.

Providers indicated the first step in locating a child who has run is to make a report to law enforcement. Providers reported mixed experiences in reporting a youth who is on the run to law enforcement, which will be covered in detail later under the section about systemic barriers to preventing a run. It was clear that providers and law enforcement do not feel the current protocols are working on behalf of the child or youth who is on the run. Participants noted that competing priorities sometimes lead to conflict between facilities and law enforcement, and meanwhile, the child is not actively being located.

> "Law enforcement pick up a radio from the facility and they hear the radio traffic. They don't come on the grounds. If they hear that someone is leaving the facility or that we have someone going out of the gate or whatever, they will drive their police cruiser either into the parking lot or down the street. If nothing else, it gives them a head start if the youth does leave grounds. Sometimes, just the sight of the cruiser itself is a bit of a deterrent to the youth to sort of snap them back into reality and be like, "Oh yeah, I don't really want to do that," or at least change directions or something. It's not always effective, but it's enough for us to continue to pay for it [contract with law enforcement], so it is something that we utilize."

> "If kids go off grounds, then we have to call and they're [law enforcement] a little grumpy about that. They're not super happy to talk to us most of the time, especially when there are repeat offenders or multiple in a short period of time. We have had comments like, 'We have more important things to do. We have real things that we need to be responding to,' stuff like that, they get real frustrated with us. We do have regular, I think quarterly meetings with kind of the administrative folks, people in charge at the police station, and we try to work things out. Ultimately, they just simply don't get the difference of why we have to call versus why they think we should call. A lot of times, it's hard to have that discussion because we don't necessarily disagree with them, but a regulation is a regulation, and so we have to do what we have to do."

Providers noted that relationships with law enforcement agencies were inconsistent due to high turnover among law enforcement professionals. Providers suggested that the Colorado Department of Human Services (CDHS) could take a larger role in communicating runaway reporting requirements to law enforcement agencies to enhance understanding of what providers are required to do when a child runs and why physical restraint on the part of the provider may not have been appropriate.

> "I think another really important thing for us is, I think CDHS needs to step in and be the one taking control over really advocating and outreaching to law enforcement to help them understand these things. We just can't do it on a high enough level to where it's truly efficient. You know? We've done so many meet-and-greets. We have barbecues for a police department and we do all this great

> work. We give them all this information, do all this great work, and then two months later the entire beat has turned around and it's all new officers. The advocacy and the knowledge or the education needs to come from CDHS to the top. Right? So that that information is being filtered down through the ranks and we are not constantly setting up barbecues and meet and greet every other month because the beat cops have all shifted in that timeframe. I think we really need CDHS to take on advocacy for this."

> "They [law enforcement] didn't really understand what our policies are, what we can do and we can't do and what our role is and what we were doing. I told them we couldn't restrain them just because they were leaving the building. They're not being unsafe but they're walking out. We can't put them in the management, she had no idea, she was very surprised about that. I think that's probably where some of the problems are stemming from."

Providers spoke to the worry and concern they have for youth who are on the run from a facility. As noted in previous sections, staff worry about children and youth being victimized while also worrying about their physical and psychological safety. The provider participants often felt stuck in what they are able to do to prevent a run and to intervene after the fact. The following quote speaks to the provider's frustration with multiple aspects of running behavior, which will also be discussed in detail in the systemic barriers section.

> "I don't think that our families understand that, because when one of their children run away and we have to explain what we did and didn't do, if I was the mother of one of those children, I would want a voice in being able to say if my child could be physically intervened with to be stopped from making really high-risk decisions. I don't think we listen to our families enough in that interpretation, because there are certain – of course, you know, we want to monitor what we're doing and not using it all the time with stuff like that, but I used to get numerous phone calls, "How do you let my kid run away? I put him there for him to be safe. How can you just say that you guys let them walk away?" and that's all a reality. Even though you've probably explained it to them, or you try to explain that the imminent risk conversation, at the end of the day, when their child is out of a safe environment, it doesn't matter how it got there. That's really scary to them, as it should be, because that's probably what they've been interfacing with or dealing with for a very long time, and now the system is involved and the system isn't keeping their kid safe anymore than they were able to. Again, I just think that I would agree that the interpretation of these and it's about compliance through a regulation versus making a decision in the moment that is around the safety of the youth."

3. What services were provided to a child or youth after a run?

> **Providers and youth described clear processes after returning from a run. Youth also indicated that the degree of connectedness they felt with providers had an impact on their ability to psychologically and physically regulate after returning to the out-of-home placement.**

Providers and youth described clear processes after returning from a run. Providers reported the need to return the child to physical and psychological safety upon their return through a physical search and assessment of overall health and well-being. Youth indicated mixed reactions from staff upon return from a run. Most youth participants felt welcomed back and understood the protocols providers needed to follow to help them reintegrate in the placement.

"In my personal opinion, I feel like they're treated a lot worse than they should be. Like you can't change your clothes. You can't wear shoes. You have to wear your slides. You have to only wear scrubs. You can't wear your personal clothes. You'll be separated, so you won't be with the unit. Which I totally, like, I get they're trying to follow protocol."

"We would do a debriefing with the youth and ask, 'How did we miss it? Were there things that we missed? Was there something that happened on the direct care side of things? Was there a phone call?' So really trying to debrief our own processes, as well, like, 'How did we miss this?' because we do. I mean, the reality is kids give us signs sometimes and we miss them, and so just learning from them both internally but also externally, including those external people, too. You know, 'Is there something that the team knew that we didn't know?' That could happen, as well, the communication or something that may have been talked about with the youth and wasn't shared with the facility."

"Those two processes, that physical and mental debriefing are so important because if we don't do that, if we don't find a way to talk about the behavior and then make a plan to correct it, we'll continue to see it over and over again because that response is what they're used to. A lot of these kids have run away, and that has been their coping skill because they're running from that unsafe environment, or they're running to go to somewhere else, and so when they get here, when something happens, their first response is that running. It's about figuring out what causes that stimulus, and then addressing it appropriately to make sure that they know that this isn't a safe behavior; while you have this coping skill, it is not an appropriate one and it's a negative, unsafe that can result in damage to you."

Youth also indicated that the degree of connectedness they felt with providers had an impact on their ability to psychologically and physically regulate after returning to the out-of-home placement. Some youth felt re-traumatized based on the nature of their interactions with law enforcement. Some youth felt staff helped them process their experience and re-integrate quickly while others felt they were mistreated upon their return to the placement. Regardless of how they were initially treated, youth reported connectedness to individuals helped them reintegrate into their programs.

"The first time I AWOL-ed, [law enforcement] brought me back, and one of the staff drove me back. [Law enforcement] escorted me to an outing van and escorted me out of there, and drove me back. I got separated on sunlight. I got restrained, and put in seclusion. They were not letting me breathe. I said just let me breathe. Like get out of my face… I put one of the lower restraints on the floor. And they were like, 'Seclusion. Put her in seclusion…I just said, "Please get off me. Like, let me breathe, Get off of me." And they're like, 'She's dangerous.' I calmed down because one of my trusted staff came to talk to me. The trusted staff was our facility Grandpa, and he talked to me. He made a joke about a giraffe because we went to the zoo the previous day. And I like I came out of it. It took one comment, and one smile, one silly joke to get me out of seclusion."

"Even though he [staff member] made me really mad that day. He also really helped me. I felt I have a few staff. I feel like they're still always there. The staff that like care for you, are always still there. Like they don't really leave you. My therapist is always there, too, they don't ever really leave you. They don't like just say, "I want to process with you," and then just walk away. They'll process with you. Maybe it might take them a few days, but like they'll get to, as soon as possible."

> "Then when a kid does return that they're welcomed back into the program… they're offered the opportunity for food, to shower or bathe, change clothing. And it should never be consequential in nature as far as upon their return. Yes, there might be something that we're going to talk about, but then it's not going to – that's not going to happen when they return. First things first, is, 'We're happy that you are back. We are happy that you are safe. Let's come inside. Let's meet your basic needs and care for you and feed you, shower, change clothes,' whatever that might be."

4. What programmatic and systemic barriers make it difficult to prevent a run from occurring?

> **Providers discussed the main barriers they encounter in preventing youth from running. These include experiences with law enforcement when a youth is on a run. Providers noted the need for clear definition of "imminent danger" in reference to C.R.S. § 26-20-102(6), a better partnership with CDHS, and funding for more staff.**

Provider participants were widely concerned about Colorado's Protection of Individuals from Restraint and Seclusion Act, which allows staff to physically prevent youth from leaving facilities only when leaving would put youth in imminent danger. Providers understand why this law exists, and they do not necessarily disagree with it, but feel their jobs and potentially licensure is on the line if they use a physical restraint to prevent youth from leaving. Providers indicated the need for clearer guidance on the practical meaning of "imminent danger."

> "Restraining is the absolute worst part of the job. It's traumatizing for everybody involved. We all know that. We do everything in our power to not go in that direction. But ultimately, when does the safety of these kids matter more than anything else? You know? And so, this has been a really hard thing for us. We've had to watch many, many impulsive kids run away and put themselves in risky situations because we were completely stopped from utilizing any higher-level intervention."

> "Runaway is not exclusive to Colorado, nor is the imminent risk issue exclusive to Colorado. But the definition is, again, just as nebulous as it can possibly be. And it needs to get buttoned down. It strikes me, for example, when we assess a child for suicidal ideation, you know, or for a risk of self-harm, we are allowed to consider ideation, and yet if it's a runaway ideation, it's not included in any kind of justification. It would be great if that could get figured out. You've got say a bad phone call. You've got an escalated young person, and they make the choice to run away. They have no cell phone, no money, no water, no preparation. In a lot of cases, they really don't know their way around. And that context is disregarded when we try to justify, you know, a measure which is well-intended and probably well justified. But it's not okay. Every provider—and this is true in every state—has backed off."

> "One thing that just really makes it difficult and should probably be discussed is just about how – a blanket rule and stuff for some of this stuff is just not going to cut it. I think that everything should be a lot more individualized. Some of our campuses with how young a kid is, you know, if you have an eight-year-old that's trying to run out of the house in the middle of winter shoeless and no shirt on, to me that would be – you're adding that risk to yourself."

Reporting requirements were also an issue for provider participants. When a report to CDHS needed to be made (the conditions for which generally appeared unclear), the providers reported feeling as if the assumption was that they had not done everything in their power to keep youth from running.

Consequently, providers were constantly in the position of having to justify their decisions. For example, one provider recalled a time where they followed a youth in a snowstorm because the youth left without warm clothing. The provider felt death could be imminent if the youth was left exposed to the elements. Based on the facility's "hands off" policy, the staff member was concerned about how their actions would be interpreted and that they could face adverse professional consequences.

> "You burn relationships all over the place where you're operating, and I think the hardest part, like I'll share an example. We had a 13-year-old young person go out in [a major snow storm], or whatever blizzard that we had, and he left in sweatpants and flipflops. I went out in my own car, and I was contemplating, "What do I do?" I was at the point where my career was on the line, you know what I mean? If he wasn't going to get into my car, I mean, as a mom, I was like, 'I cannot leave this kid out here for any amount of time.' Fortunately, he doubled back and made it back to the facility before I did in a car, so I didn't have to make that decision, but I had to think about that. All of us have been put into a situation now that you have to think about all of the things about the youth, and what you feel as a human being is in their best interest versus how it's going to be interpreted. We became super hands-off, and if kids walked away, we followed them to the perimeter, we called law enforcement, and felt really horrible about the dangerous situation we put them in, and so there is just that reality."

> "Kids have rights, yes they do, but we have duties. We have obligations to keep them safe. And that's really where we're all coming from. And the default is that we are doing something wrong, and it strikes me that if any of our own children ran away, it would be them doing something wrong. And yet – so they are placed out of the home for some difficult circumstance and, all of a sudden, what would be a mistake on their part becomes a mistake on our part."

> "If you block egress for child, you're guilty of violating their rights. And for the program you got an institutional abuse finding on that if it's determined that you blocked an egress. And so, many of us have taken to allowing kids egress and just walking around with them. For hours."

Providers and youth reported a shortage in providers as a major problem for preventing youth from running from a placement. The youth reported feeling this shortage on a personal level when they are in need of attention (e.g., talking through trauma, calming down after a triggering event, or supporting mental health needs). Providers also noted the lack of an adequate staff-to-youth ratio prevents them from recognizing signs of youth in distress or being able to assist them in regulating emotions. Youth reported they were not getting their needs met because there was not enough staff to serve the number of youth given their high needs. Providers indicated they felt the need for better collaboration between systems, including common definitions and understanding of terms, and lower provider-to-youth ratios would help them focus more on treating youth and preventing running behaviors.

> "There's not enough staff-to-youth ratio for us to ever get our needs met. We don't really get to process. And, honestly, our only way out is to run and walk out for us to be able to get talked to. We're struggling, and it's like, well, I had to deal with something else right now. The staff are here for support, and it's not really how it's going right now, for me at least."

> "Our trusted staff are like really rare to find because they don't just appear out of the blue. Like, you have to build a bond. We have to talk to them. You have to, you know, communicate with them but there is not enough of them."

"We have two staff per say eight or nine kids. And if we're pursuing a kid who's leaving, we're leaving that other staff potentially in a difficult situation. If we had the resources to have increased ratios in our programs, A, I think we could prevent more runs because we could give, you know, maybe that youth a little more individualized attention and we potentially could have the additional resource to pursue or walk along with the kid trying to encourage, reason, talk them down from continuing on. I think that's another big factor that at times at times makes it difficult in some of our programs, is just a lack of resource."

Opportunities for Prevention: Consequences and Connectedness

In the initial meetings of the Timothy Montoya Task Force, members indicated interest in what might prevent a child or youth from running. Participants indicated the following preventative factors:

- **Fear of consequences**
- **Connectedness with provider staff**
- **Connectedness with peers**

Fear of Consequences

A predominant theme for youth was the fear of consequences for running. Youth shared instances where they felt they had to start all over again once they returned from a run and lost all of the progress they made prior to the run. Participants provided examples of consequences such as extending placement when they were close to going home, losing all previously earned privileges, and losing access to belongings such as shoes or personal clothing.

"I have a background of running all the time. And I've been here for three months and I only went off campus one time. I don't want to go back into step one, do it all over again, and all my progress went down the drain. So, I think of it – so, do I want to do this? I'm just going to run for no – well, I have a reason, but run to just be in step one and come back and start all over again?"

"I was really just contemplating walking out, but one thing that really stopped me was "What benefit does this have for me? What am I realistically going to gain from being homeless and trying to live off of 7-11 food or something like that?" So, I just kind of thought about what would be better for me, even though it's not really the situation that I want to be in, and how I can get better from not doing that, and what can get better for me if I stay?"

"When you're here for a while and then you finally get passes and you don't like coming – going on a pass and seeing your family and then coming back here. Like, with my first pass, I wanted to run when I came back. But I didn't because, like I said in the beginning, I would just be in step one and do this all over again and not have passes or something like that."

Youth also reported times where they did not think about potential consequences due to being dysregulated. In these types of situations, youth do not have access to logical thinking or the ability to process the potential consequences.[31] Youth provided examples of when staff were able to intervene before they reached a critical level and successfully talked them down in part through a discussion of potential consequences.

“What helped me when a staff stopped me from running was kind of the same thing about what I have and what I don't utilize but can utilize. They said, ‘Why give up all this nice stuff just because you want something different that you could get at a later time?’”

“We’ll have a kid that has had a really bad family therapy session or a bad phone call or something and gets really upset. And so, that fight or flight kicks in and their go to is to flee in many situations, but our staff really work hard to try and intervene and just, you know, get their brain and their body back to a place where the adrenaline and the cortisol isn’t just pulsing through them. Often times when the staff are able to get their body just regulated, those compulsive urges to just take are just kind of gone. Then we can further process. But I’ve seen many, many situations where as soon as we get the kids body back to a state of regulation that impulsive urge really just – it’s dissipated.”

“I actually just had this happen with a kiddo this past weekend where he wanted to leave after a bad phone call with dad and leaned on myself because I was his therapist to really try and encourage him – or pull him out of that headspace of wanting to run. And a lot of times it’s a battle within themselves on what they’re going to do. I’ve seen it a lot where they try and lean on kind of us as their safe space to support them.”

Connectedness with Provider Staff

As demonstrated above when a provider successfully talked a youth out of a run, connectedness with a provider emerged as a strong running prevention strategy. Youth described staying where they feel safe, seen, heard, and valued. Youth indicated that taking a short walk with a staff member is all they needed to calm down, process, and return to their program. However, as discussed previously, staff shortages significantly limit providers’ ability to establish and maintain the kinds of connections with youth that allow staff to anticipate when youth are heading toward dysregulation and a potential run.

“I just want to point out like this lovely staff on the left here. I look forward to her smile every single morning. Like even if she’s [the staff] going through something, she will always come into work with a smile. I hardly ever hear, “I’m proud of you from any of my family members.” But you go to her and she’s like, “Great job. Like I’m proud of you.” She will not point out your flaws, but she will always compliment you on things that you’re doing successfully. If I’m ever sad, I just want to see her smile. And it’s just so goofy, and silly, and I love it.”

“It's connection with people, when kids have good connection and you're able to pull that person into maybe the situation that's brewing, that may help make that child be able to process differently. It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day.”

“We’re always using and putting ourselves in positions to try and intervene in a non-physical way first at the lowest level, making sure that we do have incentives in place and goals, and distractions and everything possible to prevent them, engaging them with activities. I know we now have our rec team and our rec therapists. We have the kids riding bikes around the track and getting outside, and doing things to try and prevent them from even wanting to run, but I'm going to be honest in the

fact that it's dangerous for a lot of these kids that we're working with to get out of the facility and out of staff supervision because they're on a one-to-one supervision throughout their time."

Connectedness with Peers

Peer connectedness was also reported as a means of prevention. Youth described leaning on trusted peers to talk them through issues like anger, frustration, and disappointment and felt calmer as a result. Youth also described talking to each other and rationalizing about potential consequences for running.

> "I guess me personally, I've helped out a couple friends that were in that head space of running away. But all I normally do is just sit there and talk to them and see what's going on, and then, if something's wrong and they're really just sitting there and just – I guess the best way to describe it is just sitting there and reflecting on it and just letting it bring them down in that head space. I just try to talk them out of it."

> "I've talked to people—it would be beneficial to learn how to understand the fact that whether or not it's happening instantly, something good is going to happen, whether that be something simple, like not having the opportunity to go on passes and then having the opportunity to go on passes, or discharging and having—still having restrictions at your house, and then being able to do more stuff as time goes on because you worked for it and you've earned it. So, it doesn't matter if it's instant or not; it's something that's going to happen"

Conclusion

Connectedness matters for children and youth in out-of-home placement. Connection between caregivers and youth is essential for the mental well-being for all youth, but especially for youth who have experienced trauma. Youth run as a means of getting their needs met, and at times this can result in tragedy. Young people do not always have the developmental capacity to fully anticipate or comprehend the consequences of their actions. However, connectedness is a protective factor that can serve as run prevention, intervention, and aftercare. Unfortunately, when connection is made more difficult by a workforce shortage, that puts kids at higher risk of becoming dysregulated and running.

In order to enable connectedness, treatment facilities need to be adequately staffed and have the time and support they need to make meaningful connections with youth. Providers also highlighted the need to clearly define terms in C.R.S. § 26-20-102(6) considering the variety of circumstances under which running incidents occur. Providers indicated the need to work with state agencies and law enforcement to define the word "imminent" and come up with solutions to help providers to have more autonomy in running prevention efforts.

Appendix A: Semi-Structured Interview Protocols for Youth and Providers

Youth Questions

As we talked about in the consent form, I am here today to listen to your thoughts about why young people run from out-of-home placements (like treatment facilities or foster homes). The people listening to what you have to say today want to understand more about why people run so they can make things better for you and other people who live in an out-of-home placement. I will ask you some questions about experiences you, or someone you know, has had with running. There are no right or wrong answers and you can share anything that feels important to you.

1. Why do you think young people run from out-of-home placements?
2. What was happening for you, or someone you know, right before running?
3. Do you know of someone who has thought about running but decided not to run? Tell us more about what you think it was like for them.
4. Have you ever felt like you wanted to run from an out-of-home placement? If so, did you run? Why or why not?
5. Has anyone who has stopped you, or someone you know, from running? What was that experience like?
6. How would you feel about yourself or a friend being restrained by a staff member to stop you from leaving an out-of-home placement?
7. Was there something a staff member did that made you want to run away? Was there something a staff member did that made you want to stay/not run away?
8. What do you think would stop someone who was thinking about running from running? from thinking about running?
9. Where are some of the places young people go when they run? Why do you think they go there?
10. What happens to people after they come back to the out-of-home placement after running? How are they treated? Is there anyone who helps them?
11. Is there anything I did not ask that you think I should know about people who run from out-of-home placements?

Provider Questions

The following questions were asked of provider focus group members after the informed consent and demographic questionnaires were completed.

1. Why do you think young people run from out-of-home placements?
2. Tell me about some things that are happening for young people right before a running incident?
3. How often do children you work with talk about running from their out-of-home placement?
4. Can you think about a time where a young person thought about running but did not? What was that experience like, and what do you think prevented them from running?

5. What do you think about physically restraining a young person to prevent them from running?
6. What do you think would stop someone in your placement, or children in general, someone from thinking about running?
7. Where are some of the places young people go when they run? Why do you think they go there?
8. What happens to young people in your placement when they return after a running incident? How are they treated? What supports are provided to the young person and their family? What conversations do you have with the young person regarding why they ran? What plans are discussed with the young person regarding preventing future runs or ensuring safety of the young person while on the run.
9. What, if any, have your experiences been like with law enforcement when young people run from their out-of-home placement?
10. What do you think needs to happen to prevent someone from running from the out-of-home placement where you work?
11. Is there anything else I did not ask that you think is important to share?

Appendix B: Additional Focus Group Participant Quotes by Topic

Topic I: What conditions led to running from an out-of-home placement?

Conditions that Led to a Run: Running *From*

Triggering events, disconnection with staff, and responses to previous trauma

Triggering Events

> "Often in our facility, it happens when a kid gets bad news, or gets told no to something that they're really wanting. We see kids run for numerous reasons, whether it be getting caught for doing something they weren't supposed to be doing, being held accountable, or even a phone call with a future placement that doesn't go well. Often, they're super dysregulated and not necessarily thinking about their future; it's in that moment, what's going on."

> "The majority of any clients who have actually run, and it's because they've gotten bad news from their team or they've got extension or it's like it's now side factor, they got bad news and we had nothing to do with it."

> "I definitely think that that's a pretty big factor. But I also think, since that is their team, sometimes their families call and tell them. We had a kiddo a few weeks ago that mom called and said a Dependency and Neglect case was open on her. And we didn't know that, and the kid was upset for a long time and finally it came out. Even just their families. But I do think the teams often tell them information that would be good for us to know in advance."

> "It's kind of an uphill battle for us at times to get it in place. You try to keep those kids, you know, where they're at. But I think their trying to really be with family or be around friends, that kind of stuff, is a pretty common reason as well."

> "I think there are times that we know in advance as well and are able to provide support, but I do think that it's not just their teams. It's also families. A lot of times they're with us because their families are unhealthy and have unhealthy patterns, and that comes out in phone calls, and they share stuff that they shouldn't share or we should know before they share, and that doesn't always happen unfortunately."

> "We saw a lot of times just the uncertainty that kids have around what they're being told by their teams because they couldn't comprehend what treatment was and what that looked like for them as far as how they were going to complete something, as much as we would try to break it down and have them understand. Objectives from the different players on their teams, that uncertainty and disappointment."

> "Some kids will have a bad phone call, so they're running from that even though that physically isn't here but it feels like it is."

Disconnection with Staff

"There is some staff that make it to where the youth that are causing the issue are their one priority. Like if there's a youth screaming, yelling, whatever, they said, 'Oh, wait, we're gonna have to wait to process because this is –.' It's just, it's frustrating because we don't have enough staff on the floor to process, or if we don't communicate how we feel, we get in trouble for it. It's, like, some of us don't even know how to communicate how we feel. It's hard to just tell staff how we feel, especially when it's like we don't feel that most staff listen."

"I just graduated high school here. I just, I'm trying to move forward, and I can't do that when everyone else on the unit needs something else. There's probably I think 13 or 14 people on our unit, and like day-to-day, staff when we have time for to get to three or four to be able to talk to them about what they're going through that day."

"I've never I've never AWOL-ed here. I've had the thoughts of going to AWOL, or walking out. I don't know. Maybe like the lack of consistency, or it feels like we're not being listened to sometimes."

"The de-escalation tactics are either, hey, let's sit down and talk about it. If you can't talk about being unsafe, we're just going to restrain you. It's like I either choose to be restrained, or I choose to run out of the gates because I'm so escalated, and nobody's gonna let me breathe. It feels very caged and trapped right before I have to feel like I need to walk. It's happens more often than not."

Responses to Previous Trauma

"You could have told by my face. You could have told by my body language, that I was not okay. And they just like ignored it, and pushed it off, like, oh, we're talking about the unit having bad hygiene, or bullying. It was one of those groups, and I just need to leave. I'm going to flip. And I have like talked prior to this to a staff, and said, I just need to go on a walk to get my adrenaline out. Because it's like, you know, when you have ADHD, and then you have like bad anger, like when you get to the point where, like you're mad."

"I feel like sometimes when people went AWOL, they, they feel like they can run from their fears and their problems, and I know for a fact, that's not true. You can't run from your problems. You can't run from your traumas, and from your fears. What happens before people go AWOL is that either they get so worked up, that they just can't handle it anymore, then they just walk out. It gets to the point where it builds up so much, that you can really walk out to help it feel better."

"Some youth self-harm because they just want to feel better. They want help. And so staff don't get that, they'll just like quickly give you an assignment or something like that. Yeah, they have a self-harm assignment, which I think is just – it doesn't help, whatsoever. The only kind of recognition I get is when I walk."

"A lot of times, these kids try to run away to harm themselves, as well. There are a lot of threats like, 'I'm going to run in front of traffic,' or 'I'm going to kill myself,' right before they run out the gate."

"Sometimes this place, or wherever they are, is the safest place that they have been. And I think that that scares a lot of our youth. And so, they want to run back to the place that they feel comfortable with and, like someone else mentioned, run back to their friends or and things like that. So, I think

feeling safe and secure in a place really scares them, and so, they want to go back to what they're feeling comfortable with."

"I think sometimes they're just self-sabotaging, too, like they know that they have a safe place in here and they're cared for, but then they get scared that they'll have to leave eventually so they want to sabotage themselves. They want to run away and act out to make sure they don't leave anytime soon."

"I feel like some could just be scared to come into a facility like this one. Not that there's necessarily anything to be scared of but some people might just be scared and want something different and run."

"It's just really across the board because sometimes kids can take off and they seem calm and regulated and seem like things are fine. Other times they'll take off as a result of some sort of trigger that occurred and they get really emotional and upset."

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

"There was a time where I was planning an AWOL, where I was going to find somebody's phone, to run back to a home that I was previously at. I was going to call. I was gonna, 'Hey, come pick me up. I want to come home.' It was never my plan to like go to Walmart or anything. I was just trying to find a cell phone so I can get a ride to my house. I wanted to go home. I wanted to see people that haven't seen in a while, and I'm just like, 'I miss you guys, pick me up.'"

"My sister, for instance, she's ran to, I guess, her friend's house just so it's away from family, and she can just sit there and think. Or she just goes somewhere where it's peace and quiet."

"Some kids can go on passes and just stay and not come back. It doesn't necessarily have to be like they go on the pass and then they run away. It can just be they go on the pass with their family and then they just stay with their family and don't come back."

"They [peers] sometimes just want to go home. I know a bus place not that far from here like in a town over there. One night me and [another youth] went AWOL. But then the cops came and I had to say I'd give up."

"We broke into a house. Oh, and when we have the opportunity to drink, and we have the opportunity to smoke, we're gonna do it. There was like a whole tray of alcohol sitting inside so I broke in and I stole the alcohol. I stole the iPad. I stole shoes. And we went out, and we got drunk. That's how I go when I go AWOL."

"I need to leave this place. I need to get back home."

"There's running from something and running to something…friends, drugs, the families, probably in that order…"

"I think it's discussed most within the population of like the trafficking youth. I think a big reason for that is, these traffickers know substances to keep those kids under control. Right? They know if the kid would go into placement or even run away from them that after a few days they start showing like withdrawal symptoms and they're going to run right back. I think the substance abuse stuff, it causes a lot of those conversations too. And those are the kids that we see having those conversations the most in our care, are the traffic youth."

"What they know is coping, right? They know to go and use substances, they know to go and find a place where they can do the things that make them feel good in the immediate."

Conditions that Led to a Run: Running as Typical Adolescent Behavior

"I notice that every time I've seen someone run from a home or a facility they've always went to a store for some reason. I don't know why. Maybe it's that feeling of being free and being around other people that have that same opportunity of just being free and doing their own thing."

"They [peers] usually go down the street to the skate park, somewhere to hang out with other people."

Youth Who do not Understand Consequences of Typical Adolescent Behavior or Intentional Running

"Some people end up getting chased by animals, apparently fighting bears. Laying on the side of a foothill for the night. Going to Walmart, and dyeing their hair in the Walmart bathroom. Sprinkle in some hanging out with some random homeless people under the bridge. Some people get robbed by hobos. And, you know, and get drunk, but they're still drunk two days later."

"I think a lot of people don't know where to go, but like some people go towards that cactus field out there. It was like my first place I went."

"When I went with [another youth] one time he asked people from vehicles from a skating rink like in the parking lot who came out of their vehicles, and he was sitting on the bench crying to make it look like he was injured or something. He kept on asking people for favors from like cash."

"I go most when I AWOL is – the first time, I was just out in the wilderness. The second time – well, the few first times, I was out in the wilderness. Second time, I hid in a porta-potty."

"Some people talk to random people and be like, 'I used to be like you.'"

Youth Rights and Justice

"I've AWOL-ed a lot of times while I've been here. Personally, the things that triggered me to AWOL, sometimes it's phone calls because you only get a certain amount of people o++n your call list. And the only one I can call is my mom. And it's hard sometimes because when they refuse you phone calls, it makes you – it just makes me feel like they don't care. So you feel like you need to walk out, or AWOL. But I AWOL because, usually, it's just me because I'm pissed."

"I'm pissed, and staff will process with me about it. I felt like, because when I first got here, the reason I AWOL-ed was because I wouldn't get my personals. I did not feel comfortable in the clothes that were provided here. They refused my clothes because they said that it was a privilege to have

my clothes because if my behavior isn't on point, I don't get my clothes. I was, I was just kind of angry about that."

"I guess being locked down, not being able to have freedom."

Topic II: What efforts were made to locate a child or youth after a running incident?

Contacting Law Enforcement after a Run

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

"Sometimes the police, they look at the kiddos file and their diagnosis and their history and make a really quick decision on whether the kid is high-risk or not and don't always take into account the fact that we worked hours and hours with these kids. We know these kids. We know their families. We know the background. It can be very difficult and challenging too, when you're sitting here telling a police officer like, 'This kid is high-risk. We need to – you know, you need to be looking for him, and they're like, 'Yeah, if he doesn't show up in a few hours we'll send someone out or we'll let everyone know to kind of keep an eye out.' But you know when they're telling you they're not actively looking for a kid."

Staff concern About Youth Who Run

"We saw a lot of walkaways, or running away when they would get dysregulated. We were out in the middle of nowhere, and so they would become dysregulated. Maybe they had a bad phone call, a bad visit from their family and/or client manager, caseworker, GALs [guardians ad litem], and we would just see them do that walkaway thing. Towards the end, we had a perimeter that we could follow them and try, you know, engage them to come back. With their dysregulation and their age, it did become a safety issue for them."

"I think for us, one of the things that we rely on is planned interventions. If we know that kids have a history of that unsafe behavior or running and they're looking for that freedom, we can place kids on AWOL precautions where we engage in extra supervision with these kids. We put them in clothing that is easily identifiable so if they run, we know exactly what they're wearing, so those planned interventions make a big thing. The second thing is programming, making sure that the kids are engaged in things throughout the day, and that less time for idle hands, the less time for them to really kind of make decisions for themselves, to make sure that they don't have the time to think about, 'Hey, I want to AWOL,' and then go."

Trafficking

"I used to do transportation, that I've had to go all the way to [another state] to pick up kids. I went to other states to pick up kids that went AWOL, and it's really scary to me to know, especially that that truck stop is going to be there, that there's going to be a hotel there; what are these kids going to be doing at some point in time? It is really terrifying to me."

“With our population right now, we have numerous youth that are on clinical precautions and have been for months, that if they get a hold of the wrong type of lid or the wrong piece of plastic off of a container, they've got lacerations and cuts all over their bodies. We're working with kids right now that are so out to self-harm that to allow those kids into society without having someone to intervene is scary. For us, it does determine that that is an imminent danger for themselves. Then, we also are working with a youth that we're learning over time is in imminent danger because if she gets out of the facility, she runs to a house and goes in a house—she is developmentally delayed—and then she is assaulting people with anything she finds on the road or going in front of traffic just because.”

“They go to [a store] down here. They ask for rides, they ask people to buy them whatever they need. They just steal it, they'll shoplift, they'll just go get clothes and put them on to get out of the clothes they're wearing.”

“If they go to [a local store], they can find somebody that will give them a ride to wherever it is they want to go, some random person to put them in their car, and they don't even realize the danger that they're putting themselves in, that somebody could actively be looking for some kid like that to take and do whatever it is that they want with them. They don't even realize that they could disappear, that anything could happen to them, and every time that they get brought back to the facility, because, luckily, they have been brought back, we have these conversations and they're like, ‘Oh, I didn't even think about that,’ or, ‘Nothing would have happened to me.’ They're so nonchalant, and so disconnected from the reality of what it is that could happen to them getting in a stranger's vehicle.”

“They also go to the hotel. We've had kids that have gone to the hotel and ended up in situations that we wouldn't want them to be in again, just based on getting in vehicles and then just going there because that's what they know, and that is their survival skills right there.”
“When you talk about it's dangerous to do, because they don't know what they are putting out there or what person may not find them as intriguing as they find themselves. I was surprised how many people would pick these kids up walking down a country road, or if they went the other way, it was a housing development with a golf course, as well – so there was shelter, they would find the different little shelters. Also, because of much more open access to phones and different abilities to communicate, if you're doing work at school and you know how to hack into Facebook and all those different things that you think you have firewalls against, communicating with the outside world, we definitely have kids picked up often in different locations from their friends or family, or acquaintances.”

Topic III: What services were provided to the child or youth after a run?

“We also conduct a search and shower, which is basically where they have to turn in all of their clothing that they were off campus with so we can search it. They then have to shower with lice shampoo, because we have had youth who have gone off campus who hang out with some individuals who were homeless and then contracted lice and different things, and then we provide them with facility clothing. Then, there is a big debriefing process, a processing that has to happen to discuss the behaviors and the prior events that caused that behavior, because if we don't know what caused it, we can't help make a safety plan to negate those things.”

"When possible – especially if the police brought the client back or if they came back just checking in with them. If they're able to process before going back into the milieu, then great. If they're not, we still at least need to be like, 'Are you going to be able to be safe in the milieu?' Just at least, you know, making sure they're not in any sort of headspace that's going to negatively affect the of the milieu before we bring them back there."

"It's not that we even want them [law enforcement] to be the ones intervening. Often, I'm noticing their techniques and theirs is very compliance-based, and they don't intervene in a way that we would as a trauma-informed facility, so it's not a positive thing whenever we have [law enforcement] being the ones bringing back our kids, or in physical management with our kids. I don't think I've had a time where I've felt very positive or comfortable with the way they intervene, which is not to say that they're doing anything wrong. It's just the way they're trained versus the way we are trained, which is why we try and keep our kids as close to home as possible so that we can prevent as many of these hands-on and spit-masks, and we don't slam kids, but if a kid gets out, like they did this week, and goes to swing at a cop, you're going to get slammed to the ground, and that does happen."

"They don't treat you like, 'Hey, you ran because you had an issue.' It's more like, 'You ran because you're a bad kid. Or you ran away because you needed attention or whatever.' It's not, 'You ran away. What's wrong? Why did you run?' It's never, 'What happened?' It's, 'These are the consequences now.' Consequence after consequence after consequence, to the point where I got put into seclusion. Like it was bad when I got back. I feel like I wasn't treated like a human. I felt like I was treated like an animal, or like a number. I was a stamp, you know, just put in a room to calm down."

"I guess the environment, getting with – getting you sick. If you stay out too long and it's a cold night, you'll get sick. They have illnesses that can happen. Basically, though, it's a natural consequence where you go – you run and you get picked up and go to jail. That's a natural consequence because you did it to yourself where you're getting sick."

"If you're frequented AWOL, you're frequently AWOL, you're like, 'It's not really a big deal. Just come back and get back on the program.' But if you rarely go AWOL people will ask like, 'You need help with anything? Do you need anything?'"

"When I came back from AWOLing, I didn't really get treated any differently. Everybody hated my, like, staff-wise, hated my guts, because I was already acting a fool before that. I already had a whole reputation. I was still treated absolutely horrid. Then I got changed to a different unit, and it was really great there. Anyway, but my thing is, like, staff-wise, staff will do whatever."

Topic IV: What programmatic and systemic barriers make it difficult to prevent a run from occurring?

Defining Imminent Danger

"Some of the neighborhoods that, you know, houses are located in our – we're in [a city] and the kid goes to run and we're not in the greatest neighborhoods, where does that leave us? We have gang kids that we've had where someone – you know, that's affiliated with the gang that they're in… has been killed. And this kid it has talked about paybacks and things like that. So to me that would mean he's a danger to others to others. Right? In that situation. I just think asking some questions about

where that risk lies and where it crosses over to imminent risk is some of the questions that I think need to be asked. At what point does this become an imminent risk to yourself or others?"

"There are competing rights. Kids have the right to leave the facility. I think for a lot of us we also have the view that kids have a right to safety. They have a right to be protected from being trafficked. They have a right to be protected from overdose. They have a right to be protected from being hit by a car on the side of this highway. Like, they are children. We are adults. They need to be protected by us."

"Sometimes, knowing, seeing a kid that's completely out of control, that is completely chaotic, that's saying they're going to run off campus and get hit by a car, at that point, sometimes physical intervention is absolutely needed, because when they can't manage their safety, we will have to intervene and do it for them. Physical intervention, at the end of the day, is an asset to us, to be able to maintain that safety at all points."

"Clearly, this has evolved over the last 20 years that I've been involved. We used to physically intervene with kids that were leaving, and that changed through licensing regulation, or interpretation of the licensing reg, is what I would say, because it says imminent danger and how that is interpreted, I think, is very different with circumstances and the kids that you're working with. I think, over the years, that became a really difficult thing to put into practice. You know, [another provider] just talked about they've added a cost by having to contract with the local police department."

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

Staff Shortage

"I've been asking to talk to some staff here for days now, and the only time they talk to me when I was crying yesterday when I found out my brother, I was gonna lose my brother."

"It's like staff's fault 80, 90 percent of the time, but on other hand, a lot of it isn't because of staff. It's more because there's staff that obviously are mistreating, you know, saying not okay things, all that kind of stuff, but there also are a lot of staff that will try to get your priorities met, but are incapable because there's a staff shortage, and there's only so many of them, and a lot of us."

"It does get really hard when like those people [peers] that are the problems ask to process the staff that you've been waiting to process for days, and they have been trying to get to you. That makes me really upset. Because like I've been waiting for – we're five days now. And there was another youth that asked to process, and then got processed with, which is got really frustrating to me."

"It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day."

"Unfortunately, we ebb and flow with staffing patterns in the sense of I feel like we're always green on the direct care staff, but, once again, it goes back to the people that are super good with kids tend to move away from kids. They become administrators and they become case managers, and our direct care staff are the ones that are with the kids all the time, and we definitely see a less experienced person doing the day-to-day, the hard work on the front lines."

Law Enforcement

"I think that there's just not a good understanding or knowledge of what we do and what our policies are and what we are allowed to do and what we are not allowed to do as well as there are some misconceptions we have about them and what they are able to do and incapable. A lot of it is a communication issue [with law enforcement] and that we are all working in a really sensitive field and there's a lot of pressure put on everyone from every direction who are all nervous about making the wrong decision."

Reporting Requirements to CDHS

"Even though [the child] did some transgression, something happened. Again, on youth that have histories of delinquency have all of a sudden been more empowered than they were before all that took place. And that's where we all struggled, is, you know, we love kids. We want to work with kids. We want to see them succeed. We want to see them go home and live and live happily ever after. And we work really hard to do that. And then to have the default be you're doing something wrong when you're performing your duty is just backwards. It's completely – makes no sense."

"The thing that we are really missing is the availability to make our own decision about how we intervene. We're being forced to make a decision based on compliance reasons, and that's just being honest about our situation because we typically – if feel like the scales have an overbalance on this issue of not intervening for compliance-based reasons, and I don't think we should do that. However, I don't think that should be prioritized over the safety risks of the youth leaving in all these intricate, judgmental things that happen after the fact of why you did something, or whatever. My personal opinion is that if we were allowed to monitor our own compliance-based interventions and deal with that, because we don't want to do that, that's not our mode of interacting with kids or our program setup, but everybody is with a magnifying glass judging if we're doing that or not. If we were allowed to monitor that and we were allowed to intervene when we feel like it's an unsafe situation for a kid, we would stop kids from leaving the campus, and we would handle it in our way that we are trained to handle things on the grounds."

Topic V: Opportunities for Prevention: Consequences and Connectedness

Fear of Consequences

"The consequences, because like – You'd lose your privilege for the day, three days. Lose being able to go places. You got all your stuff taken out of your room."

"When I see people who are going AWOL I remind myself I want to go home. I also want to see my family. So I just look on the bright side and don't AWOL."

"If you go AWOL for two hours, right, so two hours you're just out walking around, but like that doesn't add up to three days. Like why would you go AWOL for two hours just to have to lose everything for three days?"

Connectedness to Providers

"The staff will talk me out of it."

"Last night like a staff stopped one of the kids from going AWOL. The staff said, 'No, you're not going to go out that door.'"

"I would say the biggest thing that helped our kids stay put was when they were connected to enough staff that they felt cared about."

"I think we see this very frequently. I think we probably see this more than the kids talking about it and then actually running. Our staff are really trained in de-escalation and processing and co-regulation. And they're able to verbally tell us if they're wanting to run and verbally tell us why, then doing those things to help co-regulate and bring the kid back down has been a huge help."

"I would also say that when a young person tells you they're going to run away, when they're thinking about running away they're looking for – that's a lifeline. They're asking for help. The people that run away typically don't tell you. You might see warning signs but there won't be an outward…yeah. My experience is that when a young person says, 'I'm really thinking about running away,' he's looking for permission to stay and perhaps different support, better support, in the program that he is in or she's in."

"I agree with that. I've seen that a lot too. Like, I've had a client that would literally just say, "I'm going to run," and he'll get down to the end of the hallway but then he'll turn around and make sure staff was – but he never got out of the building. He just wanted to make sure we were following him. So I do feel like there's a lot of just following him around, processing, trying to process within an encouraging them to make the right decisions. And whether that's in their best interest."

Appendix C: Coding Strategy

Phenomenological methodology involves exploring lived experiences of people as experts in their own lives. This type of methodology involves taking a holistic view of the data to understand the phenomenon being studied, in this case lived experiences with running incidents. In this program evaluation process, the PI captured the essence of what it was like to experience a run personally, as a peer who runs, or from the perspective of the service provider. The coding process in this research approach involves the following methods: epoche, phenomenological reduction, horizontalization, imaginative variation, and synthesis of meanings and essence.[1] Each of the following steps occur in order, as the steps are intended to build upon one another, and one cannot happen before the previous step is achieved.[32]

Epoche

This first step means to refrain from holding dogmatic views of the phenomenon being studied. In order to accomplish this step, the PI and external coders evaluated any previously held biases, understandings, or judgements regarding running incidents and behaviors.

Phenomenological Reduction

The phenomenological reduction process involves viewing all participant statements in an open way and aiming to recognize any bias that may hinder the evaluators in fully understanding the participant experience. Methods used to address this were evaluator journals, listening to recorded interviews multiple times, and carefully reviewing interview transcripts.

Horizontalization

This process involves giving each participants' statements equal importance by setting aside evaluator bias or opinion. To accomplish this, the evaluator reviewed transcripts independently and worked with external coders to evaluate accuracy.

Imaginative Variation

Each external coders read transcripts according to the codebook. The PI carefully considered the possible underlying causes or influences that may have impacted participants in their experiences with running from out-of-home placements. The PI and external coders selected salient participant statements to represent the textural essence of the phenomenon that was studied.

Synthesis of Meanings and Essences

This final step in phenomenology is intended to synthesize the meaning and essence through a rich description of the phenomenon. This step is represented in the results section by integrating participant quotes.

Trustworthiness

One evaluator conducted the interviews and evaluated the transcripts. In order to reduce bias, the PI consulted with two qualitative research coders to reduce bias and subjectivity in the data analysis process.[33] Additionally, the PI used five criteria to address trustworthiness: credibility, transferability, dependability, confirmability, and authenticity.[34]

Credibility

Credibility refers to the importance of viewing each participant as an expert in their own life and experiences.[35]

Transferability

Transferability is the extent to which the results of can be applied in other contexts.[36, 37] The quality of transferability depends on the evaluator's ability to describe the evaluation process and findings for the reader to determine its applicability to their context.[38] In this report, findings were represented with direct quotes that support the findings.

Dependability

In qualitative research and evaluation, the concept of dependability is related to whether the data collected is stable over time.[39, 40] This was achieved through documenting all decisions made by the evaluator to the Colorado Action Lab Staff, the Office of Colorado's Child Protection Ombudsman, and the Timothy Montoya Taskforce.

Confirmability

Confirmability refers to ensuring the data and interpretations are accurate. In this project, the findings and interpretations were directly linked to raw data and an audit trail of data.[41, 42]

Authenticity

Authenticity is seen as the ability to represent multiple perspectives in data interpretation.[43, 44] This was accomplished through use of two external coders to review the PI's interpretation of data.

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Meeting 6 – May 3, 2023

Presentation

Facilitator Slides

Keystone Policy Center

- 11 pages -

Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement

Meeting Five

May 3, 2023

May 3, 2023

Stephanie Villafuerte, Chair
Trace Faust and Doris Tolliver, Facilitators

Welcome

- Member Roll Call
- Meeting Minutes
- Welcome Doris
- Google Drive
- Shared Media

Timothy Montoya Task Force Charter

- Mission
- Charge
- Outcomes
- Ground Rules
- Media Protocols

Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement Task Force Charter

Introduction

In the spring of 2021, the Office of Colorado's Child Protection Ombudsman (CPO) was contacted by a community member who learned about Timothy Montoya's death after he ran from an unlocked residential childcare facility and was struck by a car. The community member was concerned that the circumstances leading to his death would not be examined. The CPO reviewed Timothy's case and ultimately learned that Colorado lacks sufficient infrastructure to deter youth from running away from out-of-home placements and to ensure their well-being when they return.

In the fall of 2021, the Office of Colorado's Child Protection Ombudsman (CPO) started working with members of the Colorados General Assembly, Colorado's residential treatment provider community and other stakeholders to draft legislation aimed at addressing youth who run away from their out-of-home placement. This work culminated in the creation of House Bill 22-1375, "Concerning Measures To Improve Outcomes For Those Placed in Out-of-Home Placement Facilities." This bill established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement (Task Force).

This Charter outlines the mission, scope and objectives of the Task Force along with its guidelines, media protocols and task force roles.

Mission

This critical task force is established to analyze the root causes of why children and youth run away from out-of-home placement, develop a consistent, prompt and effective response for when children or youth run away from out-of-home placements and to recovering missing children and to address the safety and well-being of a child or youth upon their return to out-of-home placement.

Charge

Pursuant to HB 22-1375, the Task Force is required to analyze:

- The sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placements;
- The root causes of why children run away from out-of-home placements;
- The differences between runaway behavior and age-appropriate behaviors;
- The behaviors that should lead a person or facility to file a missing person report about a child;
- The relationship between children who have run away from out-of-home placement and the likelihood that the child will become a victim of crime;

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Task Force Meeting Recaps

POLICY COLLABORATIVE FOR CHILDREN & FAMILIES

KEYSTONE POLICY CENTER

Timothy Montoya Task Force | Meeting Four

March 1, 2023, Meeting Recap

Overview

The Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement is legislatively charged with analyzing the root causes of why children and youth run from out-of-home placement to help develop a consistent, prompt and effective response to responding to children and youth who run from care. It is also charged with assessing how to address the safety and well-being of children and youth upon their return to care.

Summary of Marcy 1, 2023, Meeting

> ***Directive Discussed:*** *Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))*

Examining the Use of the Term "Runaway"

Members discussed the term "runaway" and its connotations. The group focused on understanding the reasons why youth leave care, but also acknowledges that youth may not always have a choice in leaving. They will do further exploration and engage in more discussions to find a more suitable term and agreed that this conversation is essential in defining and understanding the problem.

Overview of Federal and State Laws Regarding Youth Who Run Away

Stephanie Villafuert provided an overview of federal and state laws and regulations that determine reporting requirements and protocols when youth run from out of home placement. These requirements determine the data that is collected and reported about these incidents.

Stephanie discussed the importance of federal law in dictating state laws and regulations related to youth who run away and child welfare. The federal law requires states to develop and implement specific protocols for dealing with missing youth, such as immediately reporting and locating missing youth, as well as determining the factors that contributed to them running away and their experiences while absent from care.

Certain provisions of Title 19 of the Colorado Revised Statutes (Children's Code) and Volume 7 of the Colorado Code of Regulations (Social Services Rules Staff Manual Volume 7; Child

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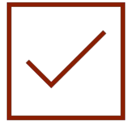
- **March 1 – Directive discussed:**
  - ***Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))***
- **April 12 – Directive/Issues discussed:**
  - ***Is current statewide, quantitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. 19-3.3-111(5)(a))***
  - ***Use of the term "runaway"***

Directive Overview

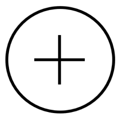
Total = 8 Ongoing = 1.5 Complete = .5



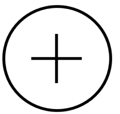
Analyze the sufficiency of statewide quantitative data.

Analyze the sufficiency of statewide qualitative data.

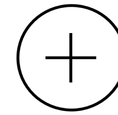
Analyze root cause of why children and youth run from care.



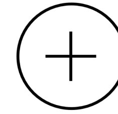
Identify and analyze behaviors that constitute running from care.



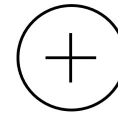
Analyze correlation between running from care and being a victim of a crime.



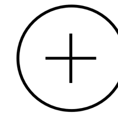
Analyze the current state laws, regulations and facility protocols.



Analyze state and national best practices for preventing youth from running from care.



Analyze how entities responsible for the care of children can coordinate responses.



Identify resources to needed to improve communication and coordination among entities.

Complete

Analyze the sufficiency of quantitative statewide data that measures the quantitative and qualitative experiences of children and youth who have run away from care. (See C.R.S. 19-3.3-111(5)(a))

- No, the majority of members do not find the current quantitative statewide data to be sufficient.
- There is a need for standard data entry and consistent extraction methods.
- Data should be able to consider the “why” behind when children and youth run from care.
- Data currently does not capture attempted or available interventions.

Ongoing

Analyze the sufficiency of qualitative statewide data that measures the quantitative and qualitative experiences of children and youth who have run away from care. (See C.R.S. 19-3.3-111(5)(a))

- Focus group report presentation on May 3, 2023.
- Member discussion and analysis

Ongoing

Analyze the root causes of why children and youth run from care. (See C.R.S. 19-3.3-111(5)(b))

Roadmap 2023

- **June 14, 2023** – What constitutes running from care?
- **July 12, 2023** – What constitutes running from care?
- **August 9, 2023** – Reflection and discussion
- **September 6, 2023** – Interim Report Finalization
- **October 11, 2023; November 1, 2023; December 13, 2023**
  Prevention: What abilities do we have to stop children and youth from running from care?

Directive for Discussion

Is current statewide, qualitative data regarding the experiences of children who have run away from care sufficient?

(See C.R.S. 19-3.3-111(5)(a))

Is current statewide, qualitative data regarding the experiences of children who have run away from care sufficient?

(See C.R.S. 19-3.3-111(5)(a))

Yes or No?

Meeting 6 – May 3, 2023

Presentation

Colorado Youth & Provider Perspectives

DU Action Lab

Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements

Kristin Myers, PhD, LPC, SSP

Lexi Wimmer, LPC, LAC

Kristin Klopfenstein, PhD

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Purpose of the Report

Questions required in HB 22-1375:

- What conditions led to running from an out-of-home placement?
- What efforts were made to locate a child or youth after a running incident?
- What services were provided to the child or youth after a running incident?
- What programmatic and systemic barriers make it difficult to prevent a run from occurring?

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Focus Group Demographics

A total of five focus groups (two providers, three youth)

- 15 out-of-home placement provider participants
- 21 youth participants ages 12-17
- Facilities located in Northern and Southern Colorado and the Front Range

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Overview of the Process

- Semi-structured interview protocol approved by Timothy Montoya Taskforce
- Focus groups were audio recorded and transcribed into written form
- Three independent researchers reviewed transcripts and developed themes
- Supporting quotes were selected and included in the report

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Report Highlights

- Conditions that led to running from out-of-home placement
- What efforts were made to locate a child or youth after a running incident
- What services were provided to a child or youth after a run
- What programmatic and systemic barriers make it difficult to prevent a run from occurring

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Lessons Learned: Opportunities for Prevention

- Consequences and connectedness
- Fear of consequences
- Connectedness with provider staff
    - Provider staff to youth ratio
- Connectedness with peers

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Key Takeaways

- Connectedness is run prevention, intervention, and aftercare.
- Youth run *from* placements when they are dysregulated or trying to get needs met.
- Youth run *to* connectedness and familiarity.
- Youth test boundaries and desire autonomy.
- Programmatic and systemic barriers make it difficult to prevent running.
- There is a need for state agencies and providers to define "imminent danger" with respect to running prevention.

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Meeting 6 – May 3, 2023

Minutes

KEYSTONE
POLICY CENTER

Timothy Montoya Task Force| Meeting 5
Meeting Minutes
May 3rd, 2023, 8:00 am-11:00 am Virtual Meeting (Zoom)
Facilitators: Keystone Policy Center (Trace Faust & Doris Tolliver)
Members: See Appendix A

Welcome & Approval of Minutes	After member welcome, Task Force chair Stephanie Villafuerte and co-chair Beth McNalley presented the March 1st and April 12th, 2023 meeting minutes for approval. The March 1st motion for approval was provided by Kevin Lash and was seconded by Jana Zinger. The April 12th motion for approval was provided by Elizabeth Montoya and was seconded by Brandon Miller. This motion was supported by 13 present Timothy Montoya Task Force members (members).
Re-Introduction to Doris Tolliver	Trace Faust re-introduces Doris Tolliver to the Task Force as a co-facilitator moving forward in the Task Force process and who was present at the April 12th meeting. Tolliver is a strategic thinker specializing in racial and ethnic equity, organizational effectiveness, change management, and business strategy development. She has spent her career working to advance the interests of vulnerable populations, serving in programmatic and leadership roles in both the private and public sectors. Members can learn more about her at this link.
Ground Rules, Charter, Mission, and, Media Relations	Trace Faust shares Ground Rules and Task Force Charter with members. Ground rules serve as guidelines that encourage productive and collaborative deliberation. It is expected in all future Task Force meetings, all members will agree to follow them and give Keystone Policy Center the authority to enforce them for the benefit of the Task Force. The charter highlights the minutes recorded will be non-attribution, roles of organizations and individuals within the Task Force, and media guidelines and expectations. Media concerns should be referred to Villafuerte and the Office of Colorado's Child Protection Ombudsman. Trace Faust also shares with members that all materials can be accessed via Google Drive including the "Meeting Recaps'' which provide a concise summary of each meeting.
Directive Review and Discussion	Tolliver outlines the overview of the directive and which portions have been actively addressed by the task force thus far. These include: ● Analyze the sufficiency of statewide quantitative data. (Addressed) ● Analyze the sufficiency of statewide qualitative data. (Ongoing) ● Analyze the root cause of why children and youth run from care. (Ongoing) ● Identify and analyze behaviors that constitute running from care. ● Analyze the correlation between running from care and being a victim of a crime. ● Analyze the current state laws, regulations, and facility protocols. ● Analyze state & national best practices for preventing youth from running from care. ● Analyze how entities responsible for the care of children can coordinate responses. ● Identify resources needed to improve communication & coordination among entities. Doris Tolliver also presents members with a roadmap for the remaining meetings in 2023. Doris Tolliver invites members to offer their feedback on the overview of the directive and roadmap. All comments are individual and are not to be attributed to Task Force:

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	● A member inquires if rather than the "why" the antecedent is more important to understanding the reasons youth run. (This is referenced within the 6th slide presented by the facilitation team under "completed") ○ Tolliver shares the "why" includes all external and impacting factors to aid in youth who run and thanks the member for their feedback as this highlighted how valuable intentional language is. The section can be revised to add underlying causes/contributions to running more explicitly. ● Multiple members share their gratitude for the roadmap, especially the time allotted to discuss prevention. Trace Faust inquires if current statewide, qualitative data regarding the experiences of children who have run away from care is sufficient via a poll. This poll was completed by 15 present members, 10 voted "no" and there were 5 abstentions.
Data Presentation	Dr. Kristin Myers, Assistant Professor of Counselor Education and Supervision at the University of Northern Colorado, in association with the University of Denver's Colorado Evaluation & Action Lab, presented the report "Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements." This report was commissioned to conduct focus groups with children and youth in out-of-home placements, as well as providers, to determine what conditions lead children to run away from out-of-home placement, the provider's efforts to locate children who have run away, and the services provide to a runaway child upon the child's return. The full report may be accessed by clicking HERE. Key takeaways shared by Dr. Myers included: • Connectedness is run prevention, intervention, and aftercare. • Youth run from placements when they are dysregulated or trying to get their needs met. • Youth run to connectedness and familiarity. • Youth test boundaries and desire autonomy. • Programmatic and systemic barriers make it difficult to prevent running. • There is a need for state agencies and providers to define "imminent danger" concerning running prevention. Tolliver invites members to give their feedback on the report presented by Dr. Kristin Myers. All comments are individual and are not to be attributed to the Task Force: ● Multiple members shared a general appreciation for the report and found it to be a powerful primer for those unfamiliar with youth who run. ● A member shares their surprise concerning a lack of mention to peer-pressure within the report. ○ Dr. Myers shared that peer pressure was loosely present, but not a main takeaway. ● A member inquires to which types of out-of-home placements were used within the report ○ Dr. Myers shared the out-of-home placement types range from high to low serving. Dr. Myers also highlights that participants in the Strengthening Connections: Youth and Provider Perspectives on Youth Running from

	Out-of-Home Placements had experience in multiple placements and this would have influenced their responses. ■ A member inquires if it would be possible to follow up with licensing verification information. Trace Faust asserts they will follow up with Dr. Myers and the team to obtain this information. ● A member shares their appreciation for the report naming youth misbehaving inherently and how external barriers like substance use, sexual abuse, and mental health issues can be amplified. ● A member inquires why Foster Care facilities were not included in the report. ○ Dr. Myers shares she agrees Foster Care Facilities should be included and this was a logistical issue rather than intentional exclusion. ● A member inquires if gangs were mentioned as a theme in the report. ○ Dr. Myers shared that gang activity and affiliation would be information often shared to providers by family members or peers rather than youth themselves. They highlight the effectiveness of connectivity with staff and providers allowing for more honest conversations. ■ This was endorsed by a member who shared how important intentional touch points can be to discovering risk factors to youth through an anecdote ● Doris Tolliver inquires if staffing has any effect on serving youth who run. Are there enough staff, or are youth who run is placed in the wrong placement for their needs ● A member shares an anecdote relating to their child, as nearly every facility their child was placed in alleged that out-of-home placement facilities didn't have enough qualified staff as the reason out-of-home placement facilities could not meet the needs of their child. ○ A member shares their awareness of staff shortage and it as an issue is universal and can not be a reason to fail youth.
Break Out Groups and Debrief	Members break into smaller groups to discuss the data presented by Dr. Myers. Questions discussed in breakout groups: ● Reflections on information and content from the report ● Would this type of process be beneficial for gathering qualitative data moving forward? ● Would this kind of data/analysis be useful to gather more regularly? If yes, what systems might have to be in place for this to occur? Frequency, etc? ● Additional thoughts/questions Task Force members entered their thoughts into a note catcher and verbally shared their conversations back to the larger group. Highlights shared from the breakout groups: ● One group shared they felt the report was helpful and has room to be expanded upon to inform multiple solutions for youth. ● Another group shared positive sentiment about the report as it adequately shares the youth's voice and would serve as a great primer for those uneducated on the topic. The group also shares that they feel TRAILS is not a system to rely on, the task force should consider all options for youth who run or have a history of running. Additional suggestions included a quarterly survey for youth, specifically those who have a history

	of running, increase buy-in by youth to trust this process/service provider, deem appropriate sized treatment before age out, and quality assurances in all levels of care. ○ Villafuerte highlights how quality control standards of care are the baseline in other states including Florida. ● The third group shared that the report was a helpful introductory piece and that they think it's important not to place blame on parents or treatment centers. Physical boundaries may be a way to track youth who run and Group 3 shared their desire to discuss more solution-based results.
Public Comment	Stephen Fisher | Senior Civil Engineer, Tetra Tech *Mr. Fisher shares that his interest in the Timothy Montoya Task Force stems from living across from the Tennyson Center since 1985. In this time, Mr. Fisher details the multiple runnings he has personally witnessed as well as the data collection, various studies, and prevention efforts that have already been employed in this time only to result in failure for the youth. Mr. Fisher shares his aspiration for the Timothy Montoya Task Force to remain focused on the immediate protection of youth. Mr. Fisher continues by highlighting the culpability of the youth running should be on the Out-of-Home placement facilities rather than the legal parent, as when the youth are in the care of the Out-of-Home placement facilities they are responsible until a youth runs. Mr.Fisher concludes by illuminating the hypocrisy of honoring agency and free will over the mental health barriers and other external factors impacting youth who run, as it is more likely these contributing and compounding factors lead to more running. Mr. Fisher shares his gratitude to the Timothy Montoya Task Force for the ability to submit comments.*
Adjourn	Villafuerte adjourned the meeting at 11:00 am

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Appendix A:

Kelly Abbott
Jenna Coleman
Sargent Brian Cotter
Ashley Chase
Chelsea Hill
Dennis Desparrois
Kevin Lash
Dr. Renée Marquardt
Beth McNalley
Brandon Miller
Becky Miller Updike
Elizabeth Montoya
Lynette Overmeyer
Stephanie Villafuerte
Jana Zinser

Appendix B:

Pam Terloar
Dixie Gray
Lauren Showers
Laurie Burney
Jackson TL

Meeting 6 – May 3, 2023

Recap

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER

Timothy Montoya Task Force | Meeting Five

May 3, 2023, Meeting Recap

Overview

The Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement is legislatively charged with analyzing the root causes of why children and youth run from out-of-home care to help develop a consistent, prompt and effective response for when children and youth do run. It is also charged with assessing how to address the safety and well-being of children and youth upon their return to care.

Summary of May 3, 2023, Meeting

Directive Discussed: *Is current statewide, qualitative data regarding the experiences of children who have run away from care sufficient? (See C.R.S. §19-3.3-11(5)(a))*

Qualitative Data

During its previous meeting the Task Force considered the sufficiency of quantitative data. Members highlighted the need for improved data entry methods and the inclusion of information about interventions attempted or available, especially because there is no existing method to extract the needed data from the statewide database, Trails. The Task Force then began to discuss *qualitative* data. Qualitative data focuses on the experiences and narratives of individuals rather than numerical counts.

During this discussion, the idea was raised of the importance of clarifying the meaning of "why" when analyzing the qualitative data related to children and youth who have run away from care. Dr. Renee Marquardt suggested using "precipitants" or "antecedents" instead of "why" to better capture the surrounding circumstances and factors that contribute to the behavior. Terms like "underlying causes" or "contributors" were also suggested to provide a broader understanding of the circumstances.

Commissioned Report: Why Youth Run, Prevention and Ensuring Safety and Wellbeing

Dr. Kristin Myers from the University of Denver's Colorado Evaluation and Action Lab presented highlights from the commissioned report aimed at providing a more comprehensive understanding of the issue of youth running away from care. The report captures the experiences of youth who run away, including their reasons for running and why they returned. It was a collaborative effort involving staff at residential child care facilities and youth currently residing at such facilities. The data and findings aligned with ongoing discussions within the Task Force. The research involved providers and youth from different regions in Colorado, with interviews being recorded and transcribed for analysis.

The report identified several factors contributing to youth running away, including trauma triggers, the search for familiarity or connection, and impulsive adolescent behavior. Efforts to locate the youth after running incidents were often constrained by protocol-driven approaches, leading to frustrations among providers who desired more autonomy. Post-run services prioritized physical and psychological safety, including debriefing and restoring a sense of calm. Programmatic and systemic barriers included ambiguous terms, concerns about consequences, limited staffing and the need for improved connection.

Dr. Meyers emphasized the significance of understanding the complex reasons behind running incidents and the role of connectedness in prevention, intervention and aftercare. She highlighted the dysregulation experienced by youth during runs and their desire for autonomy. Collaboration between state agencies and providers was emphasized to define imminent danger and develop effective prevention strategies.

In the discussion that followed, members expressed their lack of surprise regarding the report's findings but highlighted the absence of emphasis on peer pressure and group runaway tendencies among youth. Dr. Meyers acknowledged this observation, explaining that while peer pressure was mentioned, it wasn't a major theme in the conversation. Members also commented on the report's organization and appreciated the inclusion of the unexpected behavior of adolescents. They raised questions about the types of placements discussed and the potential influence of gangs, which Dr. Meyers addressed by explaining the focus of the study and the challenges of obtaining complete honesty from youth.

Breakout Discussion

During the breakout discussion, members shared insights on juvenile arrest reports, substance use disclosure, staffing issues, fear of consequences, anonymous data collection, engagement skills and the importance of a trusted staff member. They discussed funding constraints, staff-to-youth ratios, the examination of staffing in certain facilities, and the importance of resources. The conversation also highlighted the need for differentiated data capture, quality control standards, outcome measurements, and a shift towards quality-focused approaches. Recommendations included free-flowing information, individual patterns and behaviors, addressing physical boundaries, and increasing facility responsibility.

In public comment, urgency was stressed regarding the protection of runaway children, proposing increased facility responsibility for off-campus situations to enhance child safety and reduce runaways.

Meeting 7 – June 14, 2023

Agenda

Agenda - Timothy Montoya Task Force | Meeting Six

June 14, 2023 | 8am-10am

Virtual - Zoom

Facilitators: Trace Faust and Doris Tolliver

Time	Agenda	Facilitator

8:00 a.m. to 8:15 a.m.	**Welcome and Review**
	● Member Roll Call
	● Approval of Meeting Minutes
	    • May 3, 2023
	● Meeting Recap
	    • May 3, 2023
	● Where are we in the roadmap
		Trace Faust and Stephanie Villafuerte

8:15 a.m. to 8:25 a.m.	**Directives for today's conversation** ● Identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child. (See C.R.S. 19-3.3-11(5)(c)) ● Analyze best practices statewide and nationally for preventing and addressing runaway behavior, including identifying methods to deter children from running away from out-of-home placement. (See C.R.S. 19-3.3-11(5)(f)) ● Analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors. (See C.R.S. 19-3.3-11(5)(g))	Trace Faust

8:25 a.m. to 8:45 a.m.	**National Research Presentation** ● Chair Stephanie Villafuerte will present research regarding criteria used by other states when developing response protocols for children and youth who run away from care. ● Q&A	Stephanie Villafuerte
8:45 a.m. to 9:00 a.m.	**Survey Responses** ● Overview of survey response themes and discussion of possible criteria for response tool. ● Q&A	Trace Faust
9:00 a.m. to 9:20 a.m.	**Breakout Group Discussion**	
9:20 a.m. to 9:40 a.m.	**Large Group Discussion** ● Members will return to the full group and present their group’s discussion and key points.	Doris Tolliver
9:40 a.m. to 9:50 a.m.	**Public Comment**	Trace Faust
9:50 a.m.	**Closing Comments**	Trace Faust and Stephanie Villafuerte

Zoom Information

Topic: Timothy Montoya Task Force Interim Meeting
Time: Jun 14, 2023 08:00 AM Mountain Time (US and Canada)

Join Zoom Meeting
https://us02web.zoom.us/j/83565361223?pwd=dmp6RG5GL0hBZGk3V003bFgwVm5aZz09

Meeting ID: 835 6536 1223
Passcode: 711840

Meeting 7 – June 14, 2023

Materials

Pre-Meeting Survey Summary

Policy Collaborative for Children & Families

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER

Timothy Montoya Task Force

Meeting Six Pre-Meeting Survey Responses

Overview

The Timothy Montoya Task Force is currently focusing its attention on the following directives:

Identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child. (See C.R.S. 19-3.3-11(5)(c))

Analyze best practices statewide and nationally for preventing and addressing runaway behavior including identifying methods to deter children from running away from out-of-home placement. (See C.R.S. 19-3.3-11(5)(f))

Analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors. (See C.R.S. 19-3.3-11(5)(g))

During the next three meetings, the Task Force will work to develop prevention and intervention strategies for youth who run from out of home placements. These strategies will form the basis of our forthcoming task force recommendations.

Below are the submitted responses to the pre-meeting survey distributed to members.

What behaviors or circumstances are distinct to a youth or child running away from out-of-home care -- including RCCFs and foster homes -- as compared to "age appropriate" behaviors that might be considered common among all youth?

- "They may be more independent or street savvy. They don't have emotional bonds to the home. They are likely at the placement against their own wishes or their view of what is needed."
- "Behaviors related more to trauma than impulsiveness or teenage social constructs and limit testing. Patterns of putting themselves at higher risk than typical behavior. Being suicidal or homicidal. Significant substance abuse/addiction behaviors. Deviant sexual

behavior or high risk sexual behavior (e.g. with much older partners, domestically violent relationships, being trafficked).”
- “extensive trauma history, substance abuse, vulnerable to victimization”
- “Custody issues, trauma issues, foster parents can not go after them, may not return to same foster home if gone too long (disruption of care)”
- “Youth suffering from trauma or mental health disorders often develop elopement behaviors as a coping tool for stress. It removes them from the immediate stressor, provides the rush or excitement received from knowingly breaking the rules, and becomes their go-to coping skill over time.”
- “Running away has been shown to be a poor problem-solving method in my reading. I suspect it might be and indication of a substance issue, an attachment issue, or other issues better enumerated by clinicians.”

How would you define "age appropriate behaviors" for young people who run from care?

- “This response is truly anecdotal from experience: For older kids it would be to return to family or friends homes; For younger kids it would be to go to public places where they could be safe. I.E large stores, malls, strip malls or public transportation; For younger kids it would be to depart in numbers as a group.”
- “running to spend time with friends”
- “Behaviors related to typical teenage impulsiveness, minor rule breaking, going to see friends or attend events that are typical of a teenager, staying out all night, testing limits, getting angry and needing a break/running for short periods to cool off. Light experimental use of substances, age appropriate consensual sexual exploration.”
- “Leaving as a coping mechanism from stressful situations. Leaving to be with family or friends (supportive/known environment).”
- “I call it "inappropriately appropriate" behaviors (meaning it's inappropriate but not uncommon for that age). Not returning home for a non-foster care youth maybe that they are mad at parents or want to do things restricted and stay at a friends house without permission. Most non-foster care kids do not run away to "live on the streets." Many foster care kids do not care about the foster family because they are not attached to them or are used to being shuttled from one living situation to another. It becomes routine.”
- “Occasional elopement resulting from a major incident with primary caregivers, often with a specific destination in mind. ie :directly to friend or relative where they would be safe.”
- “There is no age in which running away from care is acceptable accept in the case of a dire emergency.”

What youth behaviors should lead to a person or facility to file a missing person's report after a child or youth runs away from care?

- "The fact the child departs the facility should cause a report. Connecting the child to the circumstance is important and only a report can help that happen."
- "Anytime a youth leaves a facility without permission and does not return within a couple of hours."
- "There is a reason to suspect the youth is in certain danger, youth is suicidal or homicidal, or the youth's whereabouts are truly unknown after doing some diligent checking with the professional team, family, etc., for more than 48 hours."
- "Youth has made statements of hurting themselves or others. In need of immediate medication, reasonable to believe youth is under the influence of serious drugs (i.e: fentanyl, meth). Youth failed to return home (foster home), negative contact. Youth has a history of regularly running away from facilities and not returning, should be reported immediately."
- "If they are not where they are supposed to be and all attempts at locating them in a rational, appropriate, timely manner have failed."
- "The minute the child leaves the grounds or the caregiver loses sight of the child, a report should be filed."
- "Running away when there is reason to believe the youth might or intends to stay away for a more than a short time period."

Question Four: What criteria should be used to determine the response to a child or youth who runs away from care?

- "Age; Physical medical needs (insulin dependent etc); Weather appropriate clothing; Mental health and disabilities (ability to keep self safe in world); Sexual abuse history, propensity for trafficking; Cause for departure; Historical run patterns. (Do they find their way to family/friends...or remain on streets?); Historical experiences after running. (Did they suffer negative incidents/abuse while gone?); If DHS involved, what is the risk if they return to parents?"
- "Any known factors as to why the youth chose to run and if they present an immediate danger to themselves."
- "Safety assessment, if whereabouts are known, if reasonable belief that trafficking is occurring. Known trauma triggers (e.g. police/lights/sirens or being touched when upset, etc.). Supportive adults or peers as part of the response."
- "Emergency situations require law enforcement response (under 12, danger to self or others, immediate medication required). Suicidal ideations-mental health clinician."
- "Age, circumstances prior to leaving, length of time with a facility or foster home, background, mental health/emotional response, living options, intent."
- "The response should be the same no matter what. Running away should be classified as a behavior that presents a severe threat to the safety of the child, and should bring an

appropriate response. There should never be a time when one elopement is treated less seriously than another."

- "I have no answer."

Question Five: What criteria are less important when determining the response to a child or youth who runs away from care?

- "Familiarity with city / area"
- "black and white rules like if a run happens for more than 2 hours then X punishment. Better to be individualized for the youth and situation."
- "Foster family/facility's inconvenience, time taken to locate, amount of time taken to find them."
- "Considering 'why' a child runs is less important than the fact that they have gone. All running behavior is high risk, no matter the cause."
- "I have no answer."

Urgent/Emergency Response

What are the biggest barriers or frustrations for medical/mental health professionals in making mandatory reports?

- "Young Age (under 12 years old); Physical medical conditions that could cause death (i.e. insulin dependent); Immediate Mental health concerns such as recent Suicidal ideations; Mental disabilities making it difficult for the child to assess their safety.; Not dressed for dangerous weather"
- "If the youth has been diagnosed with severe depression, schizophrenia, psychosis , under the age of 12yrs."
- "Suicidal or homicidal ideation, known trafficking, high likelihood of overdose, serious risk of bodily injury (running in subfreezing temperatures with out clothing for example). Regardless of the emergency response, communicating to professionals and family is important."
- "Under 12, IDD, suicidal with a plan vs just ideations."
- "Dangerous past behavior, past problems, medical or mental health concerns, legal issues, gang involvement."
- "All running should elicit an urgent response, but especially youth that have previously expressed suicidal ideation, mood disorders, history of trauma, and under the age of 18"
- "Running away is always an emergency."

How would you define an urgent/emergency response?

- "Immediate and significant efforts to locate the child. RCCF Staff makes efforts to follow or keep track of child until recovery"

- “If the youth has previous history of self harm or has made recent threats of self harm or suicidal thoughts.”
- “Actions necessary to prevent serious harm.”
- “An immediate report and response by law enforcement/mental health coordinated team with law enforcement to ensure the safety of the youth.”
- “Something that will likely lead to serious problems and or consequences.”
- “Physical Intervention, immediate reporting shared with social media and surrounding first response districts.”
- “For our purposes, it boils down to danger, either to the youth or the community.”

What are appropriate actions to take in circumstances that require an urgent/emergency response?

- “Law Enforcement Notification; Parent/guardian Notification; In Person searches of areas the child may go or travel through; Public notifications”
- “Notification to law enforcement.”
- “Following a youth and reporting whereabouts to a combined mental health/law enforcement team. Immediate notification of a supportive adult who can help search for the youth. Law enforcement contact with a mental health professional supporting.”
- “Immediate report to law enforcement and DCW. Law enforcement responding immediately, with hopefully the assistance of a mental health clinician support team.”
- “Notification of appropriate parties, active search, communication between parties,”
- “Physical Intervention by those staff trained in TPM holds, locked door quiet rooms if necessary, and immediate access to crisis therapy services.”
- “Reasonable efforts to resolve the situation.”

Who are the most appropriate entities or agencies to respond to circumstances that require an urgent/emergency response?

- “RCCF Staff; Local Law Enforcement; CBI for public alerts; Media organizations”
- “Law Enforcement and Human Services”
- “Law enforcement and mental health partnerships, supportive adults that the youth knows”
- “In a perfect scenario, it would be a dedicated trained team engaging with high-risk youth, removing law enforcement from having to respond.”
- “police, social workers, facility/foster families”
- “Facility Staff, on-site Resource Officers, Police”
- “The facility, law enforcement, parents. An all hands on deck response within reason.”

Moderate Response

When a youth or child runs away from care, what behaviors, diagnosis or circumstances might prompt a moderate response by professionals?

- “12 or older in age; No imminent danger due to physical or mental conditions. Left of own free-will but may not be able to provide long term care for self. Is able to seek assistance if needed.”
- “Depression, impulsivity.:
- “Run lasting longer than 24-36 hours, moderate substance use.”
- “Known substance abuse issues.”
- “There is substance abuse issues.”
- “There is evidence that the child is in a safe place or circumstances.”
- “I cannot, based on lived experience, say that any elopement situation should be treated "Moderately"
- “I don’t have an answer.”

How would you define a moderate response?

- “Non-exigent in-person search for child utilizing RCCF and law enforcement personnel.”
- “No immediate danger, has left and returned in the past.”
- “High risk behaviors that require intervention to avoid urgent safety situations.”
- “Immediate notification to service providers, to attempt to contact youth who has previously implemented a run safety plan with the youth.”
- “All children should be treated with being located with urgency.”
- “I don’t have an answer.”

What are appropriate actions to take in circumstances that require a moderate response?

- “RCCF follows child. Notification and reporting by Law Enforcement.”
- “Notification to Human Services and Parents/Guardian.”
- “Notification of team/family, trying to identify whereabouts, notification to law enforcement in case they come into contact with youth.”
- “Immediate report to Law Enforcement but would not require a law enforcement response. Immediate notification to DCW/service providers to attempt to contact youth and activate safety plan. Immediate notification to family.”
- “I don’t have an answer”

Who are the appropriate entities or agencies to respond to circumstances that require a moderate response?

- “RCCF Staff; Parents/Guardians; Local Law Enforcement”
- “Human services and facility staff.”

- "Ideally this is done by a trained team to respond to high-risk youth that partners with DCW."

Non-Urgent Response

When a youth or child runs away from care, what behaviors, diagnosis or circumstances might prompt a non-urgent response by professionals?

- "Older teen child (15+); No mental or physical impairments; Child who is able to assess their own safety left of own free will in defiance of treatment / plans."
- "Repeat behavior but returns within the day."
- "Runs to family or friends whereabouts are known, running to attend an event or participate in a social activity, runs lasting less 36 hours, some light substance use of tobacco, marijuana or alcohol"
- "Previously runs but returns within the day or 24-hours."
- "All should be taken seriously and search for."
- "All Elopement Behaviors should be treated with the most urgent response possible."

How would you define a non-urgent response?

- "Documenting event and making notifications to involved adults to help reconnect child to support and services."
- "No reason for concern or possible danger."
- "Impulsive driven choices that are more typical for this age group or have less risk (though not 0 risk) than other behaviors."
- "This requires the youth to be entered into NCIC/CCIC as missing, but there are not any safety concerns that would require an immediate response from service providers or law enforcement."
- "Unless it is confirmed they are in a safe place and it's just a matter of time to reach them, I think it should always be urgent."

What are appropriate actions to take in circumstances that require a non-urgent response?

- "Law enforcement report. Notifications to parents/guardians."
- "Notify Human Services and Parents/Guardians with details of the event."
- "Notification of professional team and family, identify whereabouts, get youth back in placement."
- "I think reporting and immediate notification to family/service providers should be done in all circumstances."

Who are the appropriate entities or agencies to respond to circumstances that require a non-urgent response?

- "RCCF Staff; Local Law Enforcement; Parent/Guardian."

- “DHS and parent/guardian”
- “Facility, DHS, family”
- “DCW”

Meeting 7 – June 14, 2023

Materials

Colorado High-Risk Victim Youth Identification Tool

Colorado High Risk Victim Youth Identification Tool

Youth Name:	DOB:
Screening Date:	Completed by:
Agency:	Case #:

Identifiers:	Source: (Indicate self-report or documentation)
☐ Three or more runs in 12 months	
☐ First run at the age of 12 or younger	
☐ Longest run more than 20 days	
☐ Credible report of commercial sexual exploitation	
☐ Found in a motel/hotel or area known for commercial sex. (See local guide for details)	

Enhancers:	Source: (Indicate self-report or documentation)
☐ Drug charges/substance abuse	
☐ Tattoos/Brands-unexplained, reluctance to explain	
☐ Truancy and/or not enrolled in school	
☐ In relationship/expressed interest in older men/women who may be intimate partner, friend or relative	
☐ Possession of expensive items, large amounts of cash, unexpected travel	
☐ Giving false info/no ID/lying about age/NOT in control of ID	
☐ Homeless, not living with adults, couch surfing, etc.	
☐ History of, or current concern about Sexual Abuse, Physical Abuse or Neglect	
☐ History of law enforcement contact related to prostitution or other charges that may occur while being trafficked (theft, drugs, assault). May have multiple curfew violations.	
☐ Stays with the individual(s) who require payment for housing. Payment could be sexual favors, drugs or money.	
☐ Family, friends, peers are known to be involved in illegal commercial sex and/or criminal activities	

Additional Red Flags:	Source: (Indicate self-report or documentation)
☐ Sexually explicit social networking profiles/chat room engagement	
☐ Demeanor: unable to make eye contact, afraid to speak	
☐ Not in control of money earned owes a debt or has an intense sense of financial responsibility toward family or intimate partner.	
☐ Using the language of the commercial sex industry ("the life"). Ask local experts for examples	
☐ Relationships/found in the presence of older, non-related adults	
☐ STIs, pregnancy, abortions	
☐ Lack of support system or supportive relationships	
☐ Cannot identify address or residence	
☐ Gang Involvement	
☐ Family dysfunction	
☐ Bruises/unexplained marks	
☐ Mental health: Fear, anxiety, depression, paranoia, PTSD, suicidal, etc.	
☐ Physical: malnourished, poor hygiene, skin rash, exhaustion, etc.	
☐ Not in control of eating and/or sleeping	
☐ Inconsistent stories-different accounts of relationships, events, etc. to different people or at different times.	
☐ Has received threats to self, family or friends if they do not work or participate in criminal activity.	
☐ Appears to be monitored-unable to have private meetings, phone conversations, whereabouts are being monitored, fear of not sharing location/who they are with	

Labor Trafficking Indicators **Source: (Indicate self-report or documentation)**

If your MDT does not have this expertise, please call the CONEHT Hotline (866-455-5075) for assistance and resources.

Labor Trafficking Indicators	Source
☐ Recruited with false promises of work conditions or pay	
☐ Works long hours with few or no breaks	
☐ Pay is inconsistent	
☐ Some or all pay goes towards debt, housing, food, etc.	
☐ Some or all pay is given to someone else	
☐ Unexplained signs of injury or illness, possibly untreated	
☐ Shows anxiety in maintain job for duty to family, intimate partner or to pay a debt to employer	
☐ Desperation to make a sale (magazines, beauty products, etc.) or for money while begging	
☐ Resides with a number of unrelated co-workers and others	
☐ Forced threatened or coerced to participate in illegal activities including drug sales	

Disclaimer: While this checklist can be a useful tool to improve identification of potential victims of exploitation, it is not a validated diagnostic tool. The checklist is intended to be used to supplement comprehensive screening, assessment and/or intake processes that explore a multitude of domains such as family, peers, school, employment, substance abuse, protective factors, etc. Even if a youth's profile suggests a presence of multiple indicators on the checklist, it does not confirm trafficking/victimization but highlights a need for further assessment. Information noted on this checklist will be part of a confidential database and only shared by professionals involved in the youth's care.

Meeting 7 – June 14, 2023

Materials

State Analysis of Response Criteria

Office of the Colorado Child Protection Ombudsman

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER

Timothy Montoya Task Force | Meeting Six

Developing a System Response to Youth Who Run From Out of Home Placements

June 14, 2023

Overview

Colorado Law fails to provide guidance to professionals about what information to report to law enforcement and what youth to prioritize for response. Below are some examples of how other state's structure laws and regulations related to youth who run from out of home placements.

Arizona
Internal DHS Agency Policy
Criteria for Reporting to LE

Immediate notification to law enforcement.

With approval of the supervisor, the DCS specialist may submit a referral to the At-Risk Runaways Service for assistance in locating a runaway child when one or more of the following circumstances exist:

- Child is suicidal.
- Child has been diagnosed with a serious mental illness, is prescribed medication for the mental illness, and may pose a danger to self and/or others if not receiving treatment and medication as prescribed.
- The child suffers from a serious physical illness and is prescribed medication, which if not available or administered properly, could place the child at risk of serious physical harm.
- The child is pregnant.
- Other specific child safety concerns exist (i.e., the child is age13 or younger, the child is with a known perpetrator of abuse or neglect, the child is significantly developmentally delayed).
- The child is known to be, or is at risk of becoming, a victim of sex trafficking. Risk factors include, but are not limited to, substance use, gang affiliation, delinquency, or previous victimization.

Connecticut

Internal DHS Policy

Criteria for Reporting to Law Enforcement

Immediate notification when:

- Child is a danger to self, others, or the community, regardless of age.
- Child has a prior history of sexual exploitation.
- Child is under age 13.

  When a child has run away from a congregate care setting, Department of Children and Families (DCF) foster home, or therapeutic foster home, ***contacting the police immediately to file a missing person report may not always be an appropriate course of action***. Factors to be considered include:
- Child's danger to self, others, or the community
- Medical and physical health
- Chronological age
- Developmental age
- Behavioral and mental health status, including prior trauma history and especially sexual abuse or exploitation
- Social and emotional functioning
- Geographical location from which the child ran.

District of Columbia

Protocols for Reporting Children Missing From Care to Law Enforcement

Citation: D.C. Code § 4-1323.01; CFSA Missing Children Policy

Criteria for Reporting to Law Enforcement/Missing and Absconder Unit

Immediate Notification when there is a High-Risk Child- a child or youth who is missing or has absconded and whose safety is compromised for one or more of the following reasons:

- Child is age 12 or younger.
- Child has one or more serious health conditions that require treatment or ongoing care (including prescription medications) that without would cause serious harm to the child.
- Child is pregnant and there is a concern that the unborn child or children in her care may be at risk.
- Child is parenting and the infant/child is believed to be with him or her and there are concerns regarding the safety of the infant child.
- Child has emotional problems that require treatment and without treatment the child is believed to be a danger to themselves or others.
- Child has a developmental disability that impairs the child's ability to care for her/himself.
- Child has a serious documented alcohol and/or substance abuse problem and could be a danger to self or others.
- Child is absent under circumstances inconsistent with his or her established patterns of behavior and this absence cannot be readily explained (i.e., is believed to have been abducted).

Florida

Protocols for Reporting Children Missing From Care to Law Enforcement Citation: Ann. Stat. §§ 39.0141; 937.021(4); Admin. Code § 65C-30.019

Criteria for Reporting to Law Enforcement

Immediate notification when: the child's caregiver, legal guardian, or child welfare professional shall immediately report a child as missing to law enforcement when any of the following apply:

- Child is under age 13.
- Child has a physical or mental incapacity or a developmental or behavioral challenge that renders the situation more dangerous than it would be for a child with more maturity or resources.
- Child is with others who may endanger his or her safety.
- Child is known or believed to be in a dangerous or life-threatening situation.
- Child is missing under circumstances inconsistent with established behaviors

Nevada

Protocols for Reporting Children Missing From Care to Law Enforcement

Citation: Child Welf. Pol. Man. MTL # 0210

Criteria for Reporting to Law Enforcement

Immediate notification when any of the following apply:

- The child is age 5 or younger.
- The child has a cognitive delay.
- The child is vulnerable due to medical needs.
- The child has runaway or abduction is suspected.

Otherwise, it is the next business day.

North Carolina

Protocols for Reporting Children Missing From Care to Law Enforcement

Citation: Child Welf. Man., Agency Plan for Abducted and Runaway Children

Criteria for Reporting to Law Enforcement

Immediate notification for High-Risk Youth:

- The child's absence is inconsistent with his or her established pattern of behavior and the deviation is not readily explained.
- The child is known or believed to be a victim of human trafficking.
- Other circumstances are involved in the disappearance that would cause a reasonable person to conclude that the child should be considered 'at imminent risk.'

Tennessee

Protocols for Reporting Children Missing From Care to Law Enforcement
Citation: Supp. to Policy # 31.
Response criteria

Immediate notification.

The DCS Absconder Unit (AU) provides assistance by prioritizing cases based on:

- Medical or mental health needs and conditions of the youth.
- Age of the youth.
- Length of time on runaway.

The type of support the DCS AU provides is determined by the **priority level**, as follows:

- **Low priority**: The DCS AU tracks and monitors the youth through available reports and contacts the regional absconder representative at least one time per month.

- **Moderate priority**: The DCS AU assists caseworkers by phone with guidance and possible resources to assist the search. DCS AU tracks the youth through social media and other media avenues to assist the caseworker in determining the possible location of the youth.

- **High priority**: The caseworker partners with the regional absconder representative to identify high-risk youth for an active search. The caseworker and DCS AU staff actively seek the youth by going to relative homes, schools, community centers, malls/shopping centers, and contacting local law enforcement. The DCS AU obtains information from known friends, associates, and relatives of the youth to identify any possible leads and known locations.

Vermont

Protocols for Reporting Children Missing From Care to Law Enforcement
Citation: Fam. Serv. Pol. Man., Policy # 155
Criteria for reporting to law enforcement

Immediate Notification

Criteria to relay to law enforcement:

- Child is intellectually or developmentally delayed or has a mental health diagnosis that would increase risk to the child.
- Child is substance dependent or requires prescribed medications.
- Child was absent for more than 24 hours before being reported to law enforcement.
- Child is in a potentially life-threatening situation.
- Child is believed to be with others who could endanger his or her welfare.
- Child is suspected or known to be a victim of sex trafficking.

- Child is currently at risk of self-harm or suicidal ideation.
- Child is absent under circumstances inconsistent with his or her established patterns of behavior and this absence cannot be readily explained.
- Child disappeared under circumstances that would lead a reasonable person to conclude that the child should be considered at higher risk.

Meeting 7 – June 14, 2023

Minutes

KEYSTONE POLICY CENTER

The Timothy Montoya Task Force: To Prevent Children From Running Away From Out-Of-Home Placement | Meeting 6

Meeting Minutes

June 14th, 2023, 8:00 am-10:00 am Virtual Meeting (Zoom)

Facilitators: Keystone Policy Center (Trace Faust & Doris Tolliver)

Members: See Appendix A

Welcome & Approval of Minutes	After member welcome, Task Force Chair Stephanie Villafuerte approved minutes from the May 3rd, 2023 meeting. The motion for approval was provided by Kevin Lash and was seconded by Vice-Chair Beth McNalley. This motion was supported by 13 present Timothy Montoya Task Force members with 0 abstentions.
Directive Review	Directives for meeting discussion: ● Identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child. (See C.R.S. 19-3.3-11(5)(c)) ● Analyze best practices statewide and nationally for preventing and addressing runaway behavior, including identifying methods to deter children from running away from out-of-home placement. (See C.R.S. 19-3.3-11(5)(f)) ● Analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors. (See C.R.S. 19-3.3-11(5)(g)) Referencing a previous data presentation, a Task Force member detailed the importance of including peer pressure as an influence for youth who run. Trace Faust and Task Force Chair Stephanie Villafuerte share their gratitude for the comment and will ensure this point will be reflected in the minutes. Villafuerte also highlights Task Force members Dr. Renee Marquardt, Kevin Lash, and Elizabeth Montoya for their consistent sharing of their nuanced expertise for the benefit of the Task Force.
National Research	Task Force Chair Stephanie Villafuerte presented informal research regarding criteria used by additional states when developing response protocols for children and youth who run away from care. This information can be found HERE. Trace Faust invites Task Force members to share their input on the data presented by Villafuerte. All comments are individual and not attributed to the Task Force. ● Absconder Units are overseen and paid by whom? ○ Task Force Chair Stephanie Villafuerte shares it is under the Department of Human Services ● Could absconder units be implemented regionally to help the smaller counties? ● Absconder Unit research was mentioned by multiple members ● Prevention is intervention ● Some members share difficulty in "ranking" youth who run with risk levels as they are all at high risk for harm ● Children should be treated equitably to ensure consistent and long-lasting change. A member shares their personal experience and highlights how youth can develop habits of running in which parents can determine if the current run is a break to cool off or a true run.This should not be a methodology used by service providers. Villafuerte invited Vice Chair Beth McNalley to discuss the High-Risk Victim Youth Identification Tool that is currently utilized (also available HERE) All comments are individual and not attributed to the Task Force.

<table>
<tr><td></td><td>The theme of training as a barrier keeps coming up. This is an important theme for the Task Force to note.</td></tr>
<tr><td>Survey Responses</td><td>Trace Faust outlines and reviews the pre-meeting survey summary (HERE). No objections to meeting summary.</td></tr>
<tr><td>Large Group Debrief</td><td>Task Force members participated in large group breakout discussions to review and disseminate information heard today. Doris Tolliver invites the two breakout groups to share their findings: Task Force members entered their thoughts into a Note Catcher and verbally shared them back to the larger group. Highlights shared from the breakout groups are as follows:
Group 1, represented by Task Force member Lynette Overmeyer, shared:

For Immediate Response

Three or more officers were looking.
Age 10-11
11 years and younger should be a priority
Life-saving medications (diabetes, seizure, heart medication)
Medical treatments (dialysis)
Psychotropic medications
Recent or current traumas (example: recently bullied/victimized)
Suicidal ideation
Historical victimization (HT; drug courier)
IDD
Social Media Responsiveness
Who is on the youth’s “team?”

Moderate Response (define: At least one agency looking for a child.)

As a parent, this criteria doesn’t apply. Cannot see a “moderate circumstance.”
Struggle with age categorization. If I have to choose; teen years. Other factors could change the response type.
-Other medications (non-lifesaving)
-Peer Pressure; copycat behaviors.

Non-Emergent Response

Group was not fond of this category
Age 18 to 21

Group 2, represented by Task Force member Beth McNalley shared:

For Immediate Response

Under 12
Immediate medication/life-threatening w/out treatment, IDD-child incapable of self-protection
Addiction drug use (fentanyl/meth)
Suicidal homicidal ideation
Identified high-risk for exploitation/HT (MDT)
Trauma response

Moderate Response

12-15
Food allergy
IDD capable of self-protection
Self-harm

Non-Emergent Response

15-17
ADHD

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KEYSTONE
POLICY CENTER

	○ Experimental drug use
Public Comment	*Pam Treloar-* *"From a provider experience, we have had law enforcement tell us that if the teen client has run several times and comes back on their own, the police may not see it as "immediate" and tells us to call back 2 hours later. As a provider, we disagree. By the time the youth is in residential care, they have high-level needs and even if a "typical, short" run occurs, there is still a risk. Chronological age is so different than developmental age too though. Updated clinical assessments/information is available to name the level of risk. Thank you"*
Next Steps and Adjourn	Task Force Chair Stephanie Villafuerte shared her appreciation for the continued dedication of the Task Force and adjourned the meeting at 10:00 am

Appendix A:
Kelly Abbott (Departed 9:30)
Ashley Chase
Jenna Coleman
Brian Cotter
Jenelle Goodrich (Departed 8:30)
Kevin Lash
David E. Lee
Beth McNalley
Brandon Miller
Becky Miller Updike
Elizabeth Montoya
Lynette Overmeyer
Stephanie Villafuerte

Appendix B:
Adrienne Palazzo
Laurie Burney
Lauren Showers
Micheal W. Teague
Pam Treloar

Meeting 7 – June 14, 2023

Recap

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER

Timothy Montoya Task Force | Meeting Six

June 14, 2023, Meeting Recap

Overview

The Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-home Placement is legislatively charged with analyzing the root causes of why children and youth run from out-of-home care to help develop a consistent, prompt and effective response for when children and youth do run. It is also charged with assessing how to address the safety and well-being of children and youth upon their return to care.

Summary of June 14, 2023, Meeting

Directives Discussed:

- *Identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child. (See C.R.S. 19-3.3-11(5)(c))*
- *Analyze best practices statewide and nationally for preventing and addressing runaway behavior, including identifying methods to deter children from running away from out-of-home placement. (See C.R.S. 19-3.3-11(5)(f))*
- *Analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors. (See C.R.S. 19-3.3-11(5)(g))*

Analyzing National Work and Current Processes

The primary directive for the current meeting is to identify and analyze behaviors that constitute running away from care, best practices for preventing and addressing runaway behavior, and how entities can coordinate a thorough and consistent response to youth who run away from care. The conversation addressed the importance of differentiating between "runaway behavior" and age-appropriate behaviors, and the need to determine which behaviors should prompt the filing of a missing report about a child.

Stephanie Villafuerte, Chair, acknowledged the importance of understanding individual characteristics of youth who run away in order to develop effective prevention and intervention strategies. She expressed

gratitude to Elizabeth Montoya and Kevin Lash for sharing their experiences with their children, which highlight the need for personalized responses and reinforce the notion that every youth is different.

Stephanie presented research across all 50 states regarding how they address the issue of children who run away from care. The federal government requires states to develop a runaway plan, covering five specific areas from reporting the runaway incident to ensuring the safety of returned youth.

Initial Phase of Reporting to Law Enforcement

While Colorado law simply requires immediate or 24-hour reporting, other states have more specific requirements, particularly regarding youth vulnerability. As previously discussed, immediate reporting does not necessarily lead to an immediate response from law enforcement due to resource constraints. However, some states have absconder units within human service departments, such as the District of Columbia and Tennessee, which prioritize locating youth who have run away from care based on specific criteria, including low, moderate and immediate priorities depending on the youth's status and history.

Examples:

- Low Priority – An older youth or situations where the child left due to family circumstances.
- Moderate Priority – Requires additional actions from human services staff, such as social media checks and regular contact with parents.
- High Priority – Involves actively locating the child or youth through various means, including visiting malls, athletic fields, and family residences.

While a few states have this extra layer of response, Colorado does not. Some states also have detailed human service manuals dedicated to runaway protocols which are worth looking at in more detail. Lynette Overmeyer pointed out that creating a manual alone will not solve the problem, and Brandon Miller asked about success rates for the absconder units and how many people are in those roles.

Doris Tolliver highlighted two points regarding the characteristics of youth who run away from care. She noted that trauma is a recurring theme mentioned by task force members, but it was not explicitly identified in the criteria for response. Additionally, she noted considering prior behavior as a basis for distinguishing between normal age-appropriate risky behaviors and behaviors that indicate a higher risk. She also emphasized that repeat runners should not be considered less at risk but rather potentially more at risk due to their pattern of behavior.

Stephanie suggested that categorizing unusual behavior as a missing person case or potential kidnapping aligns with the perspective of law enforcement and highlights the need for swift action, such as issuing an Amber Alert. Doris agreed and added that repeated running behaviors also increase the potential risk, potentially making youth more vulnerable to human trafficking. They acknowledged that both categories carry risks, and Stephanie recognized the importance of considering the criminal context in understanding the potential dangers faced by runaway youth.

Kevin appreciates the concept of an absconder unit as it establishes a single point of contact when prioritizing and locating missing youth. The current lack of a coordinated approach emphasizes the

need for collaboration among providers, family members, human services workers and law enforcement to address the vulnerability and safety of runaway youth.

Lynette suggested an important intervention strategy that is currently missing in the process of placing youth in care: gathering information from parents about where their child would go if they were to run away and documenting it in Trails. This would enable caseworkers to easily access the information and prioritize checking those locations. Collecting this information could also allow for proactive discussions with youth about safe places to go. She suggested adding this topic to the agenda for future discussions.

The task force discussed that, law enforcement may not have a deep understanding of trauma and its various manifestations in individuals. It is important to document observable behaviors that are relevant to law enforcement, such as poor self-regulation or impulse control, rather than diagnoses.

Dave Lee and Elizabeth expressed concerns about prioritizing run away events because all missing children are high risk. Labeling them low, medium and high risk is too subjective.

Denver County's Runaway, Outreach, Notification, and Intervention (RONI) Tools and Approaches

Beth McNalley discussed the tools and approaches used in Denver's RONI program, noting what the tools are supposed to do versus what they actually do. Beth's team engages in outreach and works with the Denver Anti-Trafficking Alliance multi-disciplinary team. They utilize the High-Risk Victimization (HRV) tool to identify high-risk youth for potential trafficking. However, there are barriers to using the HRV tool, including a lack of training in using and administering the tool, and when the information is put into Trails, some answers only allow yes or no, not unknown, so there is a need for careful administration to ensure accurate results. For example, whether a youth has tattoos only allows for yes or no. Without a description of the tattoos, it's not very helpful.

Also, the source of the information is important because Beth's team might not want to bring up information the youth didn't personally disclose. Her team prefers a youth-led conversation with the youth, so it can take multiple visits to fill out the tool. The Council is also looking at the harm caused by administering the tool multiple times to the same youth, forcing them to relive their trauma and preventing the team from building rapport and trust with the youth. Doris encouraged the group to think about how the tool could be more deeply integrated into practice.

Use of Social Media to Track and Locate Missing Youth

Beth provided insight into the social media presence utilized by her team in engaging with runaway youth. They have a dedicated Google number for communication, ensuring the safety of their team members. They also have accounts on platforms like Instagram and Snapchat (less so on Facebook because kids don't use it as much) as it remains consistent even when phone numbers change frequently among runaway youth. Each department may have different policies regarding social media usage, but it plays a significant role in their efforts to engage with and support runaway youth.

Task Force Member Survey and Discussion

A survey was sent to task force members ahead of the meeting to gather insights and perspectives as they discuss potential strategies. Using a summary of a survey that was sent to task force members, they

went into breakout groups. In the breakout groups, they focused discussions on specific criteria related to runaway behavior and differentiating it from age-appropriate behavior.

The breakout groups utilized a Note Catcher which had the initial categorization of immediate response, moderate response, and non-emergent response as a framework for discussions. The essence of what the group is trying to achieve is analyzing behaviors and determining the appropriate level of urgency to help determine which individuals or systems should be involved in responding to different situations.

Lynette's group: Their discussion focused on different age groups and considerations when determining the appropriate response to runaway situations. The group acknowledged that there is no circumstance where a non-emergent response would be suitable. They established parameters for immediate and moderate responses, with an immediate response involving three or more officers assigned to search for the youth, while a moderate response would include at least one officer. For children aged 12 and under, an immediate all-hands-on-deck approach was deemed necessary, while teenagers may require a slightly more moderate response due to their access to resources. Medical history, specifically life-saving medications, was identified as a factor necessitating an urgent response, while other medications would still require some level of urgency. The discussion also addressed behavioral health concerns, recent traumas, and historical victimization, which would require a more urgent response. The placement history of the youth was deemed irrelevant to the level of response needed. Lastly, the team discussed the training and techniques employed by DYS in locating runaway youth, highlighting it as a potential learning opportunity for DHS. Overall, the group emphasized the importance of recognizing the urgency and individual circumstances of all runaway youth.

Beth's group: The group shared similar struggles and concerns about categorizing the response into specific boxes, particularly with the non-emergent category. They recognized that factors beyond age could influence the level of response needed for youth older than 12. They also discussed distinguishing between children incapable of self-protection and those with intellectual or developmental disabilities. Further breakdowns were made regarding high-risk factors for human trafficking and drug addiction, considering specific substances like fentanyl or methamphetamine versus experimentation with marijuana. Standardizing the required information and communication with the response team was emphasized to ensure a trauma-informed approach and provide appropriate care and support, whether by law enforcement or other service providers. The group also highlighted the importance of addressing trauma, accommodating autistic youth, and considering additional resources for pregnant individuals.

Public Comment

Pam Treloar from Shiloh House, a provider of residential and continuum of care services, shared some insights from a clinical perspective. She mentioned that different law enforcement jurisdictions often use their own criteria to determine whether to respond to a call, which can lead to concerns and inconsistencies. She emphasized the importance of not underestimating the potential risks, as even one instance can escalate the danger for the child. Standardizing the approach was highlighted as crucial.

Pam also discussed the distinction between chronological age and developmental age when assessing the appropriate response. She also stressed the importance of utilizing updated clinical assessments to inform the response.

Meeting 8 – July 12, 2023

Agenda

Agenda - Timothy Montoya Task Force | Meeting Seven

July 12, 2023 | 8am-11am

Virtual - Zoom

Facilitators: Trace Faust and Doris Tolliver

Time	Agenda	Facilitator
8:00 a.m. to 8:10 a.m.	**Welcome and Review** ● Member Roll Call ● Approval of June 14, 2023, Meeting Minutes	Trace Faust and Stephanie Villafuerte
8:10 a.m. to 8:15 a.m.	**Task Force Progress** ● Approval of June 14, 2023 Meeting Recap ● Review of past work ● Review of Task Force Roadmap	Trace Faust
8:15 a.m. to 9:15 a.m.	**Overview and Member Panel** ● Directives for Discussion • Identify and analyze behaviors that constitute running away from out-of-home placement, analyze differences between runaway behavior and age-appropriate behaviors outside of the home or out-of-home placement, and identify behaviors that should lead to a person or facility filing a missing person report about a child. (See C.R.S. 19-3.3-11(5)(c)) • Analyze best practices statewide and nationally for preventing and addressing runaway behavior, including identifying methods to	Trace Faust

	deter children from running away from out-of-home placement. (See C.R.S. 19-3.3-11(5)(f)) • Analyze how entities responsible for the care of children who run away from out-of-home placement can coordinate a thorough and consistent response to runaway behaviors. (See C.R.S. 19-3.3-11(5)(g)) ● Development of Statewide Standards • The task force will discuss the possible development of a statewide response guide, building off the discussion and work completed during the June 14, 2023 meeting. During that meeting, the task force began discussing what level of response should correlate with various criteria, including the youth's medical and behavioral health needs, age and other factors. • Colorado's Capacity -- This discussion will start with a facilitated panel of members who represent entities that currently place or provide residential services to youth in Colorado. • Member Panel • Dennis Desparrois • Lynette Overmeyer • Brandon Miller • Dr. Renee Marquardt	

	• Michelle Bradley • Dave Lee	
9:15 a.m. to 9:25 a.m.	**Break**	
9:25 a.m. to 9:35 a.m.	**Presentation of Member Survey Results** ● The results of a pre-meeting member survey will be presented and discussed. Members were asked to respond to the following questions: • Given your professional and/or personal experience, what is your opinion regarding the development of a dedicated statewide absconder team in Colorado? Please include insights to any possible benefits or challenges a team such as this would present. • Given your professional and/or personal experience, what is your opinion regarding the development of statewide, standard guidelines for responding to youth who run away. (These guidelines could include protocols for human service departments, facilities and law enforcement.) Please include insights to any possible benefits or challenges such guidelines would present.	Trace Faust and Doris Tolliver
9:35 a.m. to 10:15 a.m.	**Breakout Group Discussion**	Trace Faust and Doris Tolliver
10:15 a.m. to 10:40 a.m.	**Large Group Discussion** ● Members will discuss the directive, panel	Trace Faust and Doris Tolliver

	presentation and survey results. Members will also share out from their breakout group discussions.	
10:40 a.m. to 10:50 a.m.	**Public Comment**	Trace Faust
10:50 a.m. to 11:00 a.m.	**Closing Remarks**	Trace Faust and Stephanie Villafuerte

For more information on the Timothy Montoya Task Force, including meeting recordings and a complete schedule of upcoming meetings, please visit coloradocpo.org

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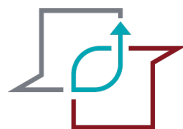

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