CHILD PROTECTION OMBUDSMAN of COLORADO

Office of the Colorado Child Protection Ombudsman

Fiscal Year 2024-25 SMART Act Presentation
Joint Judiciary Committee

January 14, 2025

Stephanie Villafuerte, Child Protection Ombudsman
Jordan Steffen, Deputy Ombudsman

How We Serve Colorado Citizens

- WHO WE ARE: The CPO is an independent state agency charged with helping youth, families and community members navigate complex child protection systems and educating stakeholders and the public.

INDIVIDUAL SUPPORT

- Provide free and confidential services
- Receive calls and online complaints
- Review more than 1,000 cases per year
- Neutrally review case records
- Answer questions and provide information
- Work to resolve concerns at ground level
- Connect people with services and resources

SYSTEMS CHANGE

- Identify and investigate systemic trends
- Illuminate issues within child protection
- Educate the public, legislators, stakeholders
- Collaborate on evidence-based solutions
- Make recommendations to the General Assembly and other policymakers to improve child protection systems and services

Increasing Caseloads

- Record 1,250 cases in FY 2023-24, resulting in a 12% increase from previous fiscal year
- CPO received 92 cases from youth clients
- Half of the cases received from youth involved youth residing at a Division of Youth Services center
- 30% of the clients served during FY 2023-24 were returning clients
- Frequent issues reviewed by the CPO include youth access to education, mental health services and helping parents access necessary services.

CPO CASE HISTORY	TOTAL # OF CASES
Fiscal Year 2015-16	580
Fiscal Year 2016-17	577
Fiscal Year 2017-18	611
Fiscal Year 2018-19	575
Fiscal Year 2019-20	725
Fiscal Year 2020-21	852
Fiscal Year 2021-22	982
Fiscal Year 2022-23	1119
Fiscal Year 2023-24	1250

Strategic Policy Initiatives

- **COMMUNITY OUTREACH**: Raise awareness of the CPO to ensure every youth and family across Colorado has equitable access to the agency's services

- **SERVICES AND PROGRAMS:** Continue to develop and strengthen efficient and effective CPO practices to better serve Colorado citizens.

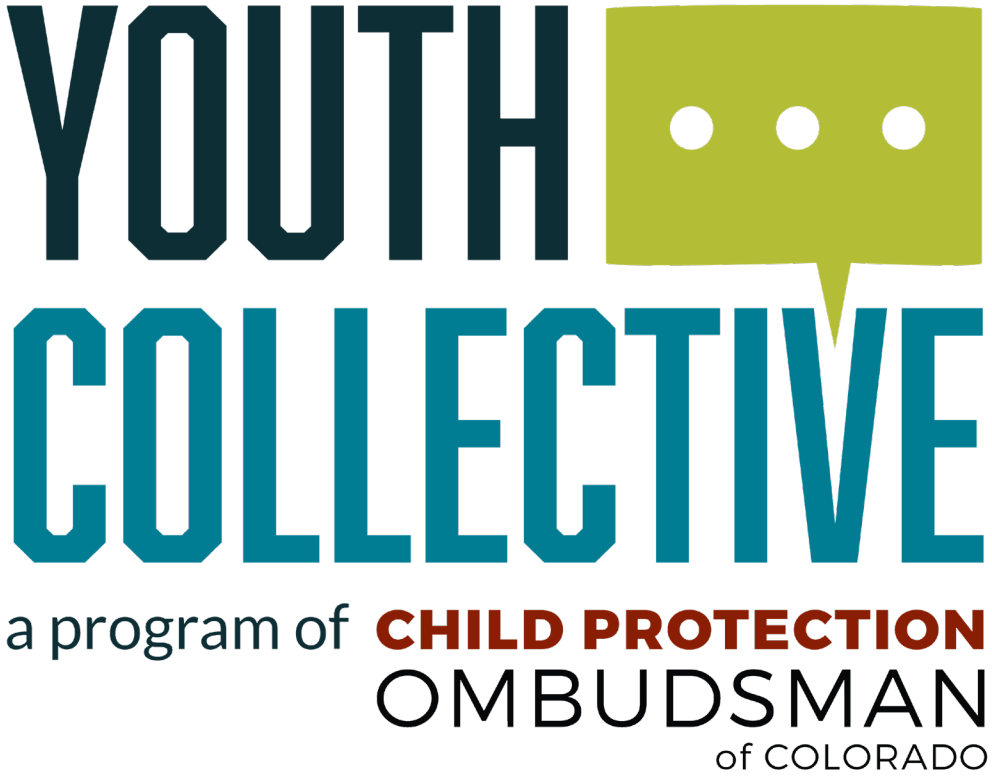
- **SYSTEMIC CHANGE:** Collaborate with youth, caregivers, stakeholders and policy makers to advance improvements to child protection services, policies and laws for every community in Colorado.

Community Outreach

- Promote awareness of the CPO among youth impacted by child protection systems to increase equitable access to services for all youth.
- Promote awareness of the CPO among communities and members of the public who are quantitatively accessing the services of the CPO less frequently than others.
- Promote awareness of the CPO among child protection professionals, including but not limited to treatment and service providers, educators, medical providers, mental health professionals and the child protection legal community.

Community Outreach

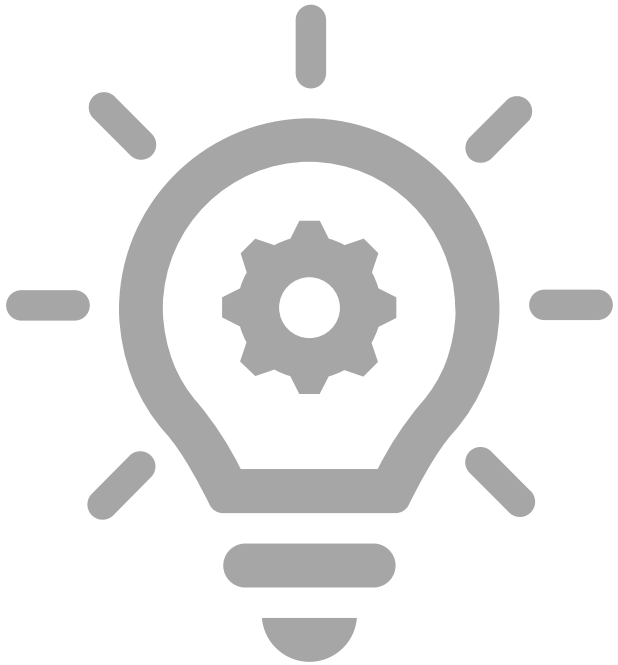
- CPO Youth Voice Collective
  - More than a dozen listening and engagement sessions with youth.
  - Youth were asked how the CPO should operate the Youth Collective program and how the CPO can inform practices to better serve them.
- Second Annual Foster Youth Voice Celebration
  - A dozen youth recognized for their efforts to improve child protection policy and law.
  - Collaboration with other state agencies, including Office of the Child's Representative and the Colorado Department of Human Services
- Expanded outreach campaign for summer 2025.



Services and Programs

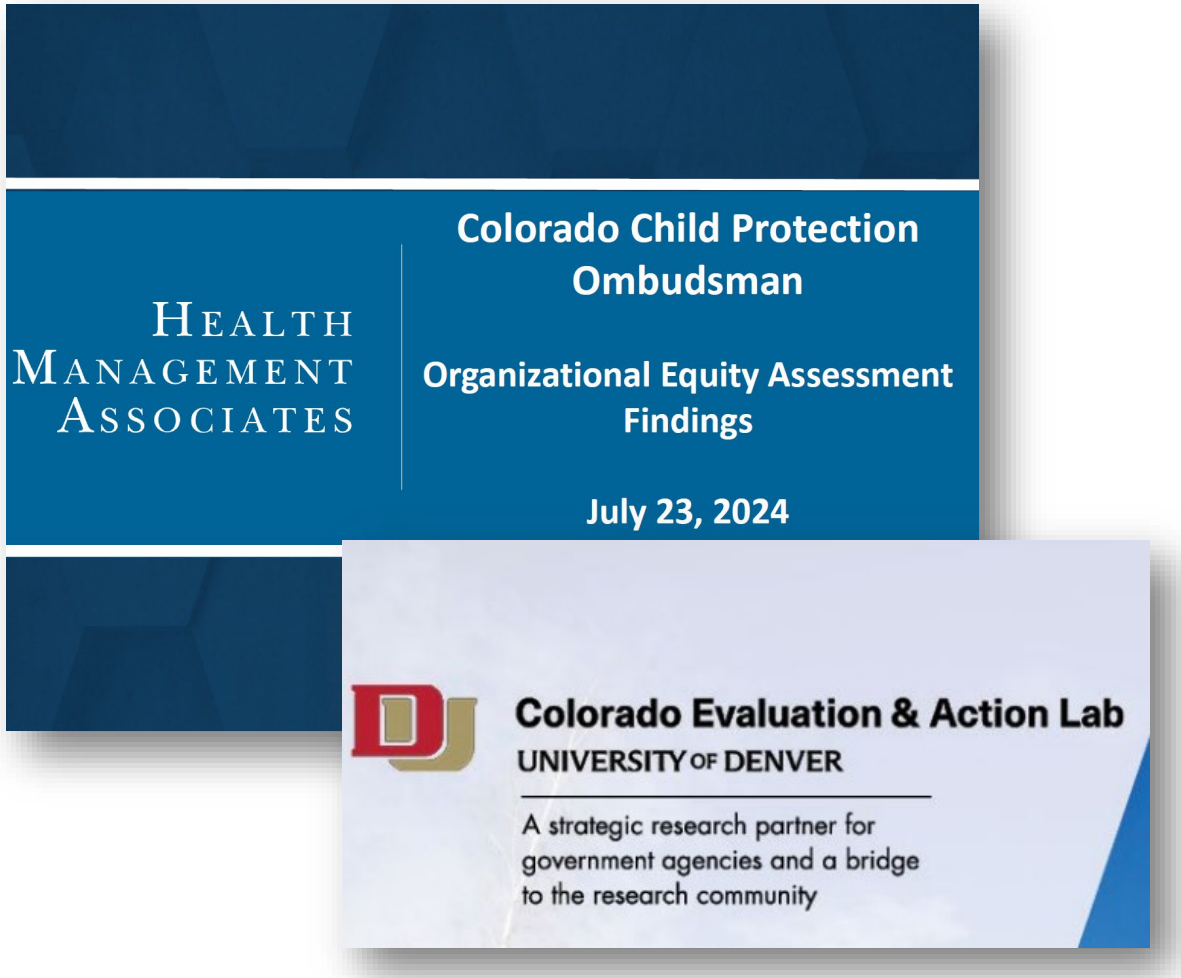
- Provide CPO staff with ongoing education and training.

- Develop inclusive processes, systems and communications that reflect principles of equity, diversity and inclusion.



Services and Programs

- Agency-wide diversity, equity and inclusion assessment and training completed in July 2024.
  - Implementation of recommendations is ongoing in 2025.
- Working with Colorado Evaluation & Action Lab to assess CPO case data for improved assessments of client outcomes and agency improvements.



Systemic Change

- Communicate findings, trending data and systemic issues to stakeholders, policymakers and the public.
- Engage youth, caregivers, policymakers, stakeholders and communities in improving Colorado child protection systems through the CPO Policy Collaborative for Children and Families.
- Serve as an independent, neutral and objective resource for legislators regarding child protection issues.

Systemic Change

- Publication of Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement published its final report and recommendations on October 1, 2024.
- The Mandatory Reporting Task Force published its final report and recommendations on January 1, 2025.

FINAL REPORT SNAPSHOT

Timothy Montoya Task Force Final Report

Introduction

In 2020, 12-year-old Timothy Montoya was hit and killed by a car shortly after running away from out-of-home care. In response to this tragedy and others like it, the Colorado legislature established the Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement. This group has just released its final report and executive summary, with recommendations for how Colorado can prevent these tragedies from happening in the future.

Problem

The task force found that the state has no standard, adequate systems in place to stop youth from leaving care, help find youth who have run, or properly care for them when they return. When the care of these young people is entrusted to the state – whether that's with a foster home or a 24-hour residential facility – the public has high expectations of the care those youth will receive. Unfortunately, there is currently a stark disconnect between those expectations and the reality those youth currently face.

EXPECTATION

REALITY

When a child attempts to run away from care, somebody will prevent them from leaving.

Children are allowed to run because of ambiguity in the law about when, how and if they can be stopped.

When a child runs away, there will be an organized response to intervene and find them.

There are no laws that require a coordinated effort to locate a child.

Once a child has been found, they will be provided comprehensive aftercare.

There are no statewide standards of care for a child when they return.

FINAL REPORT SNAPSHOT

Mandatory Reporting Task Force Final Report

Introduction

Mandatory reporting is the requirement for people in certain occupations to make a report if they have a suspicion that child abuse or neglect is taking place. The Colorado legislature created the Mandatory Reporting Task Force to issue recommendations on how to improve the state's mandatory reporting policies. The task force has just released its final report, which can be found here.

Problem

The task force was asked to clarify existing law as well as make recommendations that would address and decrease the overrepresentation of under-resourced communities, families of color and people with disabilities in the child welfare system. The goal of the task force was to create an equitable mandatory reporting system that ensures the protection of children.

The Task Force's Recommendations and Responses Revolve Around the Following Themes:

1 Recognizing and Addressing the Disproportionate Impacts of Mandatory Reporting Law and Policies

2 Clarifying Reporting Processes and Requirements

3 Creating and Requiring Mandatory Reporter Training

4 Addressing Requirements for Specialized Occupations

5 Reviewing and Improving Data and Information Systems

Ongoing Work

CHILD PROTECTION OMBUDSMAN of COLORADO

July 30, 2024

1300 Broadway
Suite 430
Denver, CO 80203

720-625-8640

coloradocpo.org

ISSUE BRIEF

Surveillance Within the Division of Youth Services: How current efforts to monitor the use of physical restraints fall short.

In August 2023, staff at a Colorado Department of Human Services – Division of Youth Services (DYS) youth center moved to physically restrain a 13-year-old in their care. As staff attempted to force him down to the floor, his face slammed into a metal doorframe. The impact resulted in a gash on the youth's face that required a series of stiches to close. A written report prepared by the staff that restrained the youth stated the physical contact was necessary because the youth made verbal threats moments before.

Less than a year prior, a different youth at a DYS youth center was in a verbal disagreement with staff when he tossed items off a staff member's desk. Staff in the room moved to restrain the youth. One member utilized an unauthorized technique during the restraint. Again, the staff involved in the incident filed a report stating that the youth's verbal comments, and his failure to respond to verbal commands made by staff, warranted physical restraint.

Twelve months before that, during October 2022, a different youth was being closely monitored after experiencing a concussion at a DYS youth center. Medical professionals at the center had advised staff to avoid physical contact with the youth. However, staff ultimately used physical force to restrain the youth after, staff reported, the youth made verbal comments that warranted such a response. The youth, however, would later report that he had been antagonized by the staff with racist language.

In each of these cases, multiple entities viewed video of the physical force used to restrain the youth. The images on those videos helped them see how staff used different physical management techniques, how the youth was escorted out of a room or whether documentation accurately reflected the incident. But any determination that the use of force was justified was made without complete information. That is because the videos of each incident only captured images of physical contact. They did not include any audio recordings of the verbal exchange staff later claimed were cause enough to use physical force.

The use of physical force within DYS youth centers has been at the center of discussions in Colorado for more than a decade. In fact, during the past two fiscal years, the Office of the Colorado Child Protection Ombudsman (CPO) was contacted by 130 youth currently or formally residing in DYS facilities. In total, 25 percent of those cases concerned staff misconduct or the misuse of physical restraints – the majority of which were called in by youth themselves. DYS leadership, legislators, attorneys and families have long worked to decrease the use of violence in youth centers each year. While

Colorado needs a plan for when caseworkers investigating child abuse lie, ombudsman says

Denver caseworker arrested over alleged false statements; ombudsman investigating half-dozen other cases

THE DENVER POST

'So disturbing': New report finds guards at Colorado juvenile detention facilities increasingly rely on use of force

CPR News

An Act

HOUSE BILL 24-1046

CONCERNING MEASURES TO ENHANCE CHILD WELFARE SYSTEM TOOLS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) The reporting and prevention of child abuse is a matter of public concern;

(b) It is the intent of the general assembly to protect the best interests of the children of Colorado and offer protective services to prevent further harm to children suffering from child abuse;

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

Where We Are Heading

QUESTIONS?

OFFICE *of* COLORADO'S

CHILD PROTECTION OMBUDSMAN

FISCAL YEAR 2024-2025
PERFORMANCE PLAN

July 1, 2024

Stephanie Villafuerte

Child Protection Ombudsman

Table of Contents

Agency Overview

Background

The Office of Colorado's Child Protection Ombudsman (CPO) was established in June 2010, under Senate Bill 10-171. This legislation provided that the CPO would operate as a program through a contract with a local non-profit agency, issued and managed by the Colorado Department of Human Services (CDHS).

The program was created in response to the deaths of 12 children in Colorado who were known to child protection services. The deaths of these children in 2007 sparked an outcry by the public that there be greater oversight, accountability and transparency of Colorado's child protection system. The public demanded the state create a mechanism to examine the components of the state's child protection system, help citizens navigate the complexity of the system and provide recommendations on how to improve the system overall.

Years after its creation, legislators determined that the CPO needed independence from the agencies it was designed to review. And on June 2, 2015, Senate Bill 15-204, Concerning the Independent Functioning of the Office of the Child Protection Ombudsman, was signed into law. The new, independent CPO opened in 2016.

Senate Bill 15-204 not only transformed the original "program" into a distinct and independent state agency, but it also created the first ever Child Protection Ombudsman Board (CPO Board). Designed to ensure the accountability and transparency of the CPO, the CPO Board is required to oversee the Child Protection Ombudsman's performance and act as an advisory body.

Since its independence, the CPO has worked consistently to keep its practices aligned with national standards. The CPO is guided by standards set by organizations such as the United States Ombudsman Association and the American Bar Association. Using those standards, the CPO works to provide a clear channel between Coloradans and the agencies and providers tasked with protecting children. Specifically, the CPO independently gathers information, investigates complaints and provides recommendations to child protection agencies, providers and the state's legislature.

Further aligning the CPO with national standards, House Bill 21-1272 was signed into law on June 24, 2021. The law allows the CPO to be more responsive to citizens requesting a review of the circumstances surrounding a critical incident, such as a child fatality. Prior to its passage, the CPO was unable to complete such reviews in a timely or robust manner. Additionally, House Bill 21-1272 created additional protections for confidential information and documents reviewed by the CPO during a case.

In June 2021 and June 2022, the CPO's duties and powers were expanded with the passage of House Bill 21-1313 and House Bill 22-1319. Intended to help unaccompanied immigrant children placed within Colorado's borders by the federal Office of Refugee Resettlement, these bills permit the CPO to

initiate reviews of the safety and well-being of such youth who are placed in state-licensed residential child care facilities, as well as monitor their care.

Also in June 2022, two task forces were established in the CPO through the passage of House Bill 22-1240 and House Bill 22-1375. Each is designed to objectively examine issues that are critical to improving the state's child protection system and are comprised of members with diverse experience and knowledge. The Mandatory Reporting Task Force, established by House Bill 22-1240, will analyze 19 directives concerning the procedures and effectiveness of Colorado's child abuse and neglect mandatory reporting system and possible improvements. The Timothy Montoya Task Force to Prevent Children From Running Away From Out-Of-Home Placement (Timothy Montoya Task Force), established by House Bill 22-1375, will analyze nine directives aimed at improving safeguards for children in out-of-home placement who have runaway behaviors.

The CPO, housed within the Colorado Judicial Branch, is located at the Ralph L. Carr Judicial Center in Denver. Colorado's current Child Protection Ombudsman is Stephanie Villafuerte. Child Protection Ombudsman Villafuerte was appointed in December 2015 by the CPO Board and took office in January 2016.

Mission

We ensure Colorado child protection systems consistently, fairly and equitably deliver services to every child, youth and family across our state.

Case Support

- Guide youth, families and community members in navigating complex systems
- Review cases to ensure the highest attainable standards of care
- Work with people and agencies to help resolve concerns and disputes at the ground level

Systems Change

- Engage communities across Colorado in addressing local and statewide problems
- Collaborate with stakeholders and lawmakers to improve services, policies and laws

Vision

Child protection systems that effectively serve every youth, family and community in Colorado.

Major Agency Functions

Role of the CPO

The CPO was created to ensure the state's complex child protection system consistently provides high-quality services to every child, family and community in Colorado. The agency:

- Listens to people about their experience with, and concerns about, the state's child protection system.

- Researches concerns reported by any individual or entity about service delivery within Colorado's child protection system.
- Resolves issues by determining the best way to assist people. This may mean bridging communication barriers or mediating conflicts based on misunderstandings.
- Identifies trends where the child protection system's funding, resources or practices are not keeping up with the needs of children, youth and families.
- Makes public recommendations for child protection system improvements. This may mean working with lawmakers, professionals and other stakeholders to advance legislation and policies that have a lasting, positive impact on children, youth and families.

Responsibilities of the CPO

The CPO is responsible for responding to citizens' complaints concerning actions or inactions by child protection agencies that may adversely impact the safety, permanency or well-being of a child. Child protection agencies are those that receive public funds to protect or care for children. This includes but is not limited to law enforcement, mental health agencies, child welfare services and the Division of Youth Services (DYS).

The CPO may self-initiate an independent and impartial investigation and ongoing review of the safety and well-being of an unaccompanied immigrant child who lives in a state-licensed residential child care facility and who is in the custody of the Office of Refugee Resettlement of the federal Department of Health and Human Services as set forth in 8 U.S.C. sec. 1232 et seq. As part of this responsibility, the CPO may create and distribute outreach materials to state-licensed residential child care facilities and to individuals that have regular contact with unaccompanied immigrant children.

Additionally, the CPO is responsible for informing on systemic changes to promote better outcomes for, and improve the safety and well-being of, children, youth and families receiving child protection services in Colorado. Being uniquely situated to gather and share information with state and non-state entities, the CPO may issue recommendations to enhance the state's child protection system. The CPO shares this and other information with the public by publishing reports and other content at www.coloradocpo.org.

Jurisdiction and Environment

Each year, the CPO provides free and confidential services to hundreds of citizens who have questions and concerns about the state's child protection system. These citizens include parents, grandparents, kin, youth, medical professionals, lawyers, social workers, police officers and many others.

Citizens' questions and concerns often relate to specific program areas within the state's child protection system, including child welfare, juvenile justice and behavioral health. With access to child protection records that are not otherwise available to the public, the CPO is able to independently

and objectively resolve citizens' questions and concerns while concurrently identifying systemic issues afflicting the child protection system.

The agency's enabling statutes are C.R.S. § 19-3.3-101 — 19-3.3-110. Pursuant to C.R.S. § 19-3.3-103, the CPO has the authority to:

- Receive complaints concerning child protection services.
- Request, access, and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint.
- Independently and impartially investigate complaints.
- Seek resolution of complaints.
- Recommend changes and promote best practices to improve the state's child protection services.
- Educate the public concerning strengthening families and keeping children safe.
- Self-initiate an independent and impartial investigation and ongoing review of the safety and well-being of any unaccompanied immigrant child who lives in a state-licensed residential child care facility and is in federal custody.

The CPO does not have the authority to:

- Investigate allegations of abuse and/or neglect.
- Interfere or intervene in any criminal or civil court proceeding.
- Testify in a court proceeding in which the CPO is not a party.
- Provide third-party records/documents acquired in the course of a case.
- Investigate complaints related to judges, magistrates, attorneys or guardians ad litem.
- Overturn any court order.
- Mandate the reversal of an agency/provider decision.
- Offer legal advice.

Summary of Fiscal Year 2023-24 Quarters 3 and 4 Performance Evaluation

During Quarter 3 (Q3) and Quarter 4 (Q4) of Fiscal Year (FY) 2023-24, the CPO worked on three Strategic Policy Initiatives (SPI) to advance the agency's work in the areas of communication and outreach, efficient and impactful practices, expanding expertise and promoting best practices. They included:

- Target communications and engagements to better educate and serve citizens and stakeholders.
- Implement practices that ensure efficient and effective CPO services.
- Establish the CPO as a leader on issues facing the child protection system.

To access the CPO's SMART Act reports, please click **here** or visit the website of the Colorado Governor's Office of State Planning and Budgeting.

Strategic Policy Initiatives

SPI 1: COMMUNITY OUTREACH: Raise awareness of the CPO to ensure every youth and family across Colorado has equitable access to the agency's services.

The CPO is statutorily required "*to help educate the public concerning child maltreatment and the role of the community in strengthening families and keeping children safe.*" See C.R.S. § 19-3.3- 103(2)(c).

The CPO has identified the following strategies, critical processes, key metrics and outcomes as ways to increase the public's knowledge of the CPO's services while concurrently learning how best to engage with various communities.

Strategy: Target communications and engagements to strengthen the CPO's statewide presence and services.

The CPO will work to ensure that all communities in Colorado have equal access to CPO services and information. Expanding engagement with communities less familiar with the CPO –particularly populations which are overrepresented in the child protection system – is key to promoting impactful, equitable reforms to Colorado's child protection system.

Critical Process: Promote awareness of the CPO among youth impacted by child protection systems to increase equitable access to services for all youth.

Key Activities

FY 2024-25

- Utilize the CPO's Tori Shuler Youth Voice Program to continue connecting with children and youth. The information gathered during the initial outreach tour during FY 2023-24 should be used to develop a multi-year youth outreach campaign that raises awareness of the CPO and its services for youth.
- Continue utilizing youth focus groups and research from previous fiscal years, to update outreach materials that directly target youth who are involved in Colorado's child protection systems.
- Promote the agency's services for youth through digital content and distributing printed materials to agencies, providers and communities serving youth in out-of-home placements.

FY 2025-26

- Key activities are completed yearly.

FY 2026-27

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development of a CPO youth outreach campaign plan, including a fiscal analysis of projected costs for maintenance of youth outreach efforts.
- Distribution of new youth promotional materials, in both English and Spanish, as measured by digital impressions and the number of sites in which printed materials are distributed.
- Increased services to youth, as measured by an increase in cases initiated by youth.

Critical Process: Promote awareness of the CPO among communities and members of the public who are quantitatively accessing the services of the CPO less frequently than others.

Key Activities

FY 2024-2025

- Develop targeted, multi-year outreach campaigns that raise awareness of the CPO and its services specific to various communities across the state.
- Promote the agency's services through digital content and distributing printed materials to agencies, providers and communities across the state.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Distribution of new promotional materials, in both English and Spanish, to agencies, providers and communities across the state.
- Continue to monitor the contacts the agencies receive from members of the public in different communities.

Critical Process: Promote awareness of the CPO among child protection professionals, including but not limited to treatment and service providers, educators, medical providers, mental health professionals and the child protection legal community.

Key Activities

FY 2024-2025

- Directly engage child protection professionals and entities interested in the CPO's services through meetings, trainings and educational opportunities.
- Promote the CPO's services for child protection professionals through digital content and distributing printed materials to non-metro agencies, providers and communities.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Outreach with professionals/providers, as measured by the number of engagements completed per quarter.
- Distribution of new professional promotional materials, in both English and Spanish, as measured by digital impressions and the number of sites in which printed materials are distributed.
- Increased services to child protection professionals, as measured by an increase in cases initiated by child protection professionals.

SPI 2 – SERVICES AND PROGRAMS: Continue to develop and strengthen efficient and effective CPO practices to better serve Colorado citizens.

The CPO is statutorily required "to receive complaints concerning child protection services made by or on behalf of a child relating to any action, inaction, or decision of any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of the child." See C.R.S. § 19-3.3- 103(1)(a). The CPO delivers a wide variety of services pursuant to its statute. These include one-on-one services for clients who contact the agency with concerns or questions regarding the child protection system, reviewing critical incidents – such as child fatalities – and monitoring the safety and well-being of unaccompanied immigrant children residing in state-licensed facilities.

The CPO has identified the following strategies, critical processes, key metrics and outcomes as ways to help ensure efficient and effective CPO services.

Strategy: Provide ongoing professional development opportunities for CPO staff.

The high demand for CPO services requires staff to be efficient in contacting citizens, identifying their concerns and determining what is necessary to help citizens resolve their inquiry. Ensuring CPO staff are supported will, in turn, ensure the CPO is providing services in an efficient and effective manner. The Critical Processes below, combined with the CPO's policies outlined in the CPO's Case Practices and Operating Procedures, will help the CPO provide all citizens quality services.[1]

[1] For more information about the CPO's practices and procedures, please refer to the Office of the Colorado Child Protection Ombudsman' Case Practices and Operating Procedures.

Critical Process: Provide CPO staff with ongoing training and education.

Key Activities

FY 2024-2025

- Have CPO staff attend ongoing training for various subjects to support ongoing program development and primary functions of the agency. Training subjects include customer services, negotiation and mediation strategies, child welfare policy and practice, ombudsman theory and practice, equity, diversity and inclusion and other applicable child protection issues.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- The total number of trainings and educational opportunities attended, as measured by the CPO's community outreach spreadsheet.[2]

Strategy: Apply principles of equity, diversity and inclusion to the CPO's services.

Critical Process: Develop inclusive processes, systems and communications that reflect principles of equity, diversity and inclusion.

Key Activities

FY 2024-2025

- Utilizing the final report created by the contracted equity, diversity and inclusion specialist during the previous fiscal year, implement any needed changes in the agency's case practices or operating procedures.
- Resources permitting, contract with an equity, diversity and inclusion (EDI) specialist to provide continuous evaluation of the CPO's internal culture, processes and business landscape.
- Provide CPO staff with ongoing EDI educational opportunities.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development and implementation of an EDI strategic plan.
- The total number of EDI educational opportunities attended, as measured by the CPO's community

[2] Every month, CPO staff record community outreach activities for the CPO Board in a spreadsheet, detailing conferences, trainings, meetings, presentations and other engagements with child protection system stakeholders.

outreach spreadsheet.

SPI 3 – SYSTEMS CHANGE: Collaborate with youth, caregivers, stakeholders and policymakers to advance improvements to child protection services, policies and laws for every community in Colorado.

The CPO is statutorily required "*to recommend…systemic changes, to improve the safety of and promote better outcomes for children and families receiving protection services in Colorado.*" See C.R.S. § 19-3.3-130(2)(e). Additionally, the CPO must "*…promote best practices and effective programs relating to a publicly funded child protection system and to work collaboratively…regarding improvement of processes.*" See C.R.S. § 19-3.3- 103(2)(d).

To promote positive systemic changes, best practices and effective programs, the CPO must produce high-quality work in a timely manner while building strong partnerships with others working within the state's child protection system. The CPO has identified the following strategies, critical processes, key metrics and outcomes as ways to encourage collaboration, identify areas of the child protection system in need of improvement, efficiently communicate its findings and ensure recommendations are being considered and/or implemented.

Strategy: Provide consistent, timely and informative communications regarding the CPO's services, ongoing projects, ombudsman practice and findings.

Critical Process: Communicate findings, trending data and systemic issues to stakeholders, policymakers and the public.

Key Activities

FY 2024-2025

- Produce consistent reports on CPO data to local and statewide stakeholders and policymakers.
- Publish and distribute CPO publications that educate the public, stakeholders and policymakers on trending issues with Colorado's child protection systems.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Stakeholder and policymaker awareness of child protection issues, as measured by the number of publications distributed.
- Public awareness of child protection issues, as measured by digital impressions and/or media engagements per quarter.

Strategy: Encourage citizens and stakeholders to use the CPO as a resource to improve the child protection system.

Critical Process: Engage youth, caregivers, policymakers, stakeholders and communities in improving Colorado child protection systems through the CPO Policy Collaborative for Children & Families.

Key Activities

FY 2024-2025

- Facilitate the Mandatory Reporting Task Force, as established by C.R.S. § 19-3-304.2.
- Produce and publish the final report detailing the work of the Mandatory Reporting Task Force and any recommendations for improvements, pursuant to C.R.S. § 19-3-304.2(10).
- Facilitate the Timothy Montoya Task Force to Prevent Children from Running Away from Out-Of-Home Placement, as established by C.R.S. § 19-3.3-111.
- Produce and publish the final report detailing the work of the Timothy Montoya Task Force and any recommendations for improvements, pursuant to C.R.S. § 19-3.3-111(7)(b).
- Continue outreach and education efforts through the CPO's Tori Shuler Youth Voice Program to connect with children and youth in Colorado and educate them about the services of the CPO.
- Educate and engage caregivers, policymakers and other child protection stakeholders in discussions around child protection issues and ideas for improvement.
- Participate in multidisciplinary task forces addressing child protection issues.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Publication of the statutorily required Mandatory Reporting Task Force Final Report.
- Publication of the statutorily required Timothy Montoya Task Force Final Report.
- Engagements with youth on systemic change, as measured by the number of current and former youth engaged through the Tori Shuler Youth Voice Program.
- Education and engagement of caregivers, policymakers and other child protection stakeholders, as measured by the number of caregivers, policymakers and child protection stakeholders engaged.
- Participation in stakeholder processes, as measured by the number of stakeholder, task force, working group and statute review meetings attended.

Critical Process: Serve as an independent, neutral and objective resource for legislators regarding child protection issues.

Key Activities

FY 2024-2025

- Survey every member of the Colorado General Assembly about their concerns, and the concerns of their constituents, regarding child protection systems and issues.
- Using survey data, directly engage legislators that express an interest in learning more about child protection systems or collaborating on policy solutions to trending issues.
- Provide testimony in front of General Assembly committees on select bills with an impact to child safety and/or child protection systems.

FY 2025-2026

- Key activities are completed yearly.

FY 2026-2027

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Legislator concerns and interest in child protection issues, as measured by the number of General Assembly survey responses.
- Engagement with legislators, as measured by the number of meetings or other interactions between the CPO and legislators.
- Engagement with the Child Welfare System Interim Study Committee, as measured by the number of presentations to the committee.

Conclusion

The Child Protection Ombudsman respectfully submits this report to the Joint Budget Committee and the General Assembly, as is required under C.R.S. § 2-7-204. The CPO will comply with its requirements under the statute and will submit the required reports and evaluations.

OFFICE *of* COLORADO'S

CHILD PROTECTION OMBUDSMAN

ANNUAL REPORT

FISCAL YEAR 2023–24

LISTEN INVESTIGATE RESOLVE IDENTIFY TRENDS LASTING CHANGE

LETTER FROM THE OMBUDSMAN

Dear friends and community partners,

It is my pleasure to present the Office of the Colorado Child Protection Ombudsman's Annual Report. This is the eighth year that I have had the privilege of leading this organization and to co-create with our team, thousands of people and community partners to build a quality child protection system that provides services to children and families in an effective, efficient and compassionate manner.

Child welfare systems across our state serve some of our most vulnerable children, youth and families. These systems are designed to support families and to protect children from harm through an array of prevention and intervention services. Once families enter the Colorado child protection system, our agency works with them to ensure that they receive the best quality services possible.

This year our agency worked with more than 1,200 citizens to address concerns that they have about the state's child protection system. Our work took us into the lives of parents, young adults, children, extended families and child protection professionals across the state. In many of these instances, individuals confided in us the deeply personal experiences that brought them into the state's child protection system. They also shared the challenging and often frustrating interactions they experienced once in the system. In each case, our team helped these individuals navigate challenges and, in many instances, find resolutions to their concerns.

Additionally, we took the experiences that they shared and used this information to promote child protection reform. While we are statutorily charged with conducting systems reform work, we also consider it our moral imperative to do so. We believe that every person who contacts our agency has a unique voice that provides us and the entire child protection community with an opportunity to reflect, learn and grow.

During the past year, our systemic policy work has been reflected in three different projects. Two projects involve our two community task forces. One task force is addressing the disproportionate impact of mandatory child abuse reporting laws on Colorado children and families and our second task force is building systems of care for youth who run away from out-of-home placements, such as foster care and residential treatment facilities. In each instance, these task forces were formed because of citizens who came to our agency and expressed concerns that Colorado could and should do better for its children and families.

Our third project is designed to prioritize the experiences of youth who are in the child protection system. This year we started the Tori Schuler Youth Collective, a program that is dedicated to helping us connect with children, youth and young adults who have experience with the Colorado child protection system. We have already learned a great deal from these youth who share with us what is working, what is not and how we can improve the quality of care for all of them.

In the end, our agency is only as successful as the people who are willing to share their experiences and our ability to listen and integrate their experiences into our work. Our commitment today and in the years to come is to remain humble and vigilant learners who transform individual experience into systems of change that we can all be proud of. This report reflects this year's listening and learning.

Sincerely,

Stephanie Villafuerte

Stephanie Villafuerte
Colorado Child Protection Ombudsman

CONTINUED GROWTH

CPO TOTAL CASE ACTIVITY IN FY 2023-2024

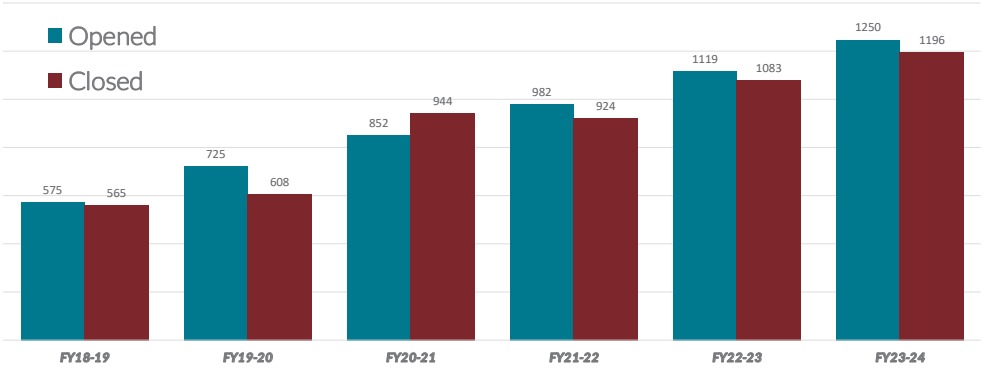
Fiscal Year 2023-24 marked the fifth consecutive year the Office of the Colorado Child Protection Ombudsman (CPO) experienced an increase in the number of cases it received from citizens. In total we opened a record 1,250 cases – demonstrating an almost 12 percent increase compared to the previous fiscal year. Similar to previous years, there are several factors that the CPO attributes to this increase in cases. These include increased outreach and education efforts to child protection professionals and children and youth. However, this year, the CPO saw a significant increase in the number of cases involving clients who had previously worked with the CPO. During the fiscal year, 30 percent of the clients served by the CPO were repeat clients. We were extremely excited to see so many clients return and seek the services of the CPO. Additionally, the number of cases referred to the agency by county departments of human services nearly doubled.

CPO CASE HISTORY	TOTAL # OF CASES
Fiscal Year 2015-16	580
Fiscal Year 2016-17	577
Fiscal Year 2017-18	611
Fiscal Year 2018-19	575
Fiscal Year 2019-20	725
Fiscal Year 2020-21	852
Fiscal Year 2021-22	982
Fiscal Year 2022-23	1119
Fiscal Year 2023-24	1250

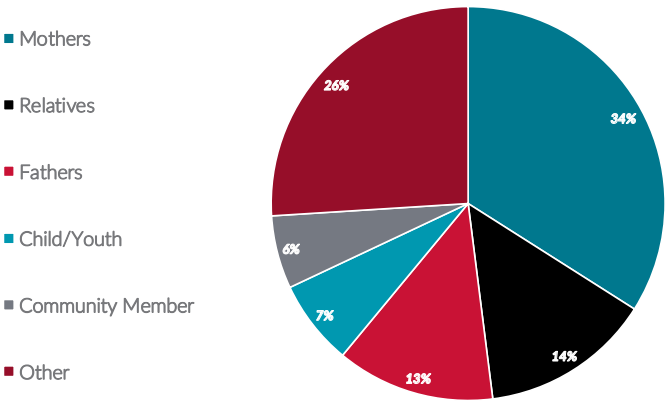
For the third consecutive year, we saw an increase in the number of cases brought to the agency by youth. During FY 2023-24, we received a total of 92 cases from youth clients. Of the youth-initiated cases closed by the CPO, half of them involved youth currently residing in the Colorado Department of Human Services' Division of Youth Services (DYS).

More than half of the total cases opened during the past fiscal year were brought to us by families of children and youth involved with the child protection system. In particular, reports filed by mothers accounted for 43 percent – 407 cases – opened by the CPO. Some of the issues most frequently raised included youth safety in the DYS, foster homes and residential facilities. We also reviewed several cases that involved ensuring youth access to education, mental health services and helping parents access necessary and required services – such as adequate parenting time.

CASES BY FISCAL YEAR



RELATIONSHIP TO CHILD



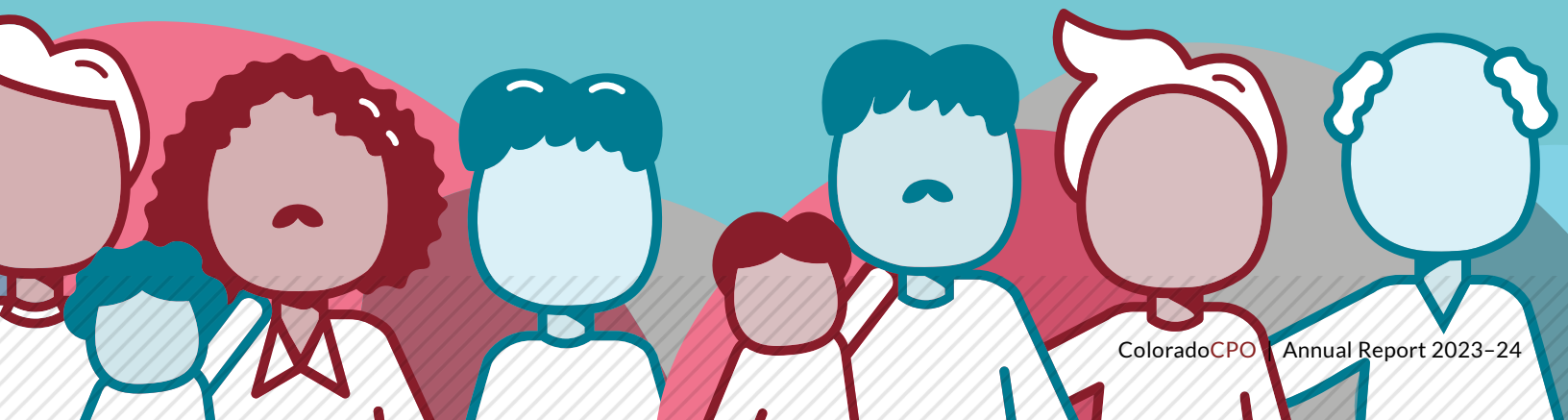
CASE HIGHLIGHTS

Case #1

The mother of a 13-year-old called the CPO with concerns about her son's safety inside a DYS youth center. The mother reported that her son's face was slammed into a metal door frame while staff attempted to physically restrain him. The impact resulted in a gash on the youth's face that required a series of stiches to close. This was one of many restraints the youth experienced while in the DYS' care. The CPO reviewed the case, including a report written by one of the staff that was involved with forcing the youth to the ground. In that report, the staff wrote that the youth was making verbal threats towards the staff after the youth's phone conversation with his family was disconnected. That phone call was with his mother, discussing details about an upcoming ceremony to celebrate the youth's brother who had recently passed away. According to the report, the staff justified physically forcing the youth to the ground because the youth allegedly made threatening statements. In addition to the written report by staff the CPO also reviewed video of the incident. The CPO watched the staff force the youth to the floor and his face hit the doorway. But the video did not contain any audio that would help the CPO confirm the youth had made verbal threats toward staff. This was just one of many cases in which the CPO reviewed a case involving a DYS youth who was physically restrained because staff claimed they either made threatening remarks or ignored staff's verbal directions. However, none of the videos produced by the DYS included audio that would help confirm staff's justification of the restraint. Ultimately, the CPO produced a brief detailing how the safety and well-being of youth may be compromised without better surveillance inside DYS facilities. The CPO will continue to work with the Colorado General Assembly to improve surveillance within DYS facilities.

Case #2

The CPO was contacted by the mother of two children who were residing in a Colorado foster home. The mother was concerned that a firearm was accidentally discharged in the foster home while her children were in a different room. No one was harmed in the incident, but the CPO reviewed the case and quickly found concerns with how the event was reviewed and documented by the agency in charge of licensing and monitoring the foster home. This agency is commonly referred to as a child placement agency, CPA. The CPO's review confirmed that the firearm was discharged after the foster father cleaned the firearm and was placed back inside a closet. Foster parents are permitted to keep a firearm in their home, so long as certain safety protocols are followed. The CPA correctly followed state regulations when reviewing the incident and ensured the father attended necessary firearm safety classes. However, the CPO also found that the CPA failed to create and enter a report about the incident into the statewide child welfare database, Trails. Reports of such incidents are required to be submitted into the database so that county child welfare services and the CDHS – which are legally responsible for children and youth in foster care – are made aware of the incident. This information can be crucial when these entities are working to determine whether to place children and youth in a particular foster home. The CPO contacted the CPA and presented them with the regulation requiring the report be submitted. The CPA stated it did not think the incident originally qualified under the regulation. However, after working with the CPO, the agency recognized the need for the report to be entered into Trails to ensure all child welfare professionals have complete information when considering placing children in the care of the foster parents.



CASE HIGHLIGHTS

Case #3

A 17-year-old transgender youth contacted the CPO while living in a treatment center located in a different state. The youth had received information about the CPO before leaving Colorado and sought the agency's help in obtaining gender-affirming medical care. The youth told the CPO she was placed in a treatment facility in a state that is legally prohibited from providing gender affirming care. Colorado facilities are currently allowed to provide such care. She was placed there because there were no available placements in Colorado. The youth reported to the CPO that she felt "stuck" in the out-of-state facility and that her legal representation was not helping her move to a different treatment center. The CPO reviewed the case and found that the judge that placed the youth in the out-of-state treatment center did so reluctantly. The youth's history of running away from care and other behaviors had resulted in her being denied admittance to several facilities in Colorado. The judge ordered the out-of-state placement to avoid the youth being forced to live in a hotel – without any therapies or services – until a different placement option became available. The CPO continued to follow the case and found that, while the local county department was continuing efforts to find a placement in Colorado, the youth's counsel had failed to follow through in assisting these efforts. Because the youth stated she was not receiving clear and meaningful communications about her case, the CPO worked to provide her updates regarding her case. Ultimately, the youth was transferred to a placement in Colorado. The youth remained in contact with the CPO during this transition and was grateful for the agency's attention to her case. She stated that she will continue to use the CPO as a resource and will ensure other transgender youth are aware of the CPO's services.

Case #4

The CPO reviewed a case in a rural jurisdiction in which the wrong person was found to be responsible for the neglect of two teenagers. During its review, the CPO learned that child welfare services became involved with the family after a firearm was accidentally discharged at a party hosted at the teenagers' home. The teenagers' parents were home during the party and were aware that alcohol and drugs were being used by under-aged guests. The parents did not maintain supervision of the party. During the party, a firearm was accidentally discharged, and a guest suffered a non-life-threatening injury to their leg. The child welfare worker assigned to the case incorrectly identified the person responsible for the lack of supervision as a 20-year-old guest of the party. As a result, the parents were never assessed by child welfare services as to whether they could properly supervise and care for the teenagers. After the CPO informed the county department of this error, the department quickly moved to correct the issue. Ultimately the parents were founded for failure to supervise their children. Additionally, the 20-year-old incorrectly accused of failing to supervise the teenagers had the finding removed from their record. In discussing the case with the county department, the CPO learned that the department was struggling to recruit and maintain experienced staff. Without experienced staff, the department was struggling to maintain quality control of its cases. This is one of a number of cases the CPO has reviewed in which staffing issues have contributed to errors in handling child welfare cases. The CPO continues to monitor this trend.

> **"She stated she will continue to use the CPO as a resource..."**

FISCAL YEAR HIGHLIGHTS

Timothy Montoya Task Force to Prevent Children and Youth from Running Away from Out-of-Home Care

During the 2022 legislative session, the Colorado General Assembly created the Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement through House Bill 22-1375. This task force was placed in the CPO's Policy Collaborative for Children & Families and met 12 times during FY 2023-2024. The task force has addressed a range of topics including ways to prevent youth from running from out of home placements to developing appropriate responses when they return. The CPO has provided a great deal of research detailing how other states have approached similar issues in their states. Speakers from Texas and Vermont as well as local nonprofits such as Foster Source have shared their experiences and perspectives at task force meetings. In recent months, the task force's focus has worked to finalize recommendations intended to develop standard, statewide programs to better serve these youth. On October 1, 2023, the task force issued its 2023 Interim Report, and its final report will be published on October 1, 2024.

Mandatory Reporting Task Force

The Colorado General Assembly created the Mandatory Reporting Task Force during the 2022 legislative session with House Bill 22-1240. The task force was placed in the CPO's Policy Collaborative for Children & Families, and the CPO has convened the task force 17 times during FY 2023-2024. To support the work of the task force, the CPO created many resources compiling related policies used in other states, including an interactive 50-state comparison of mandatory reporting laws. Task force meetings also included presentations from external speakers, including employees from the state of New York's warmline system and Evident Change, a decision-support tool creating organization. The final report of the task force will be published and submitted to the Governor and General Assembly by January 1, 2025. In its final months, the task force is working on finalizing its recommendations for changes to improve the state's mandatory reporting laws and child protection system.

Addressing Transparency and Practice Concerns in Washington County

During the summer of 2023, we notified the CDHS of serious child welfare practice concerns at the Washington County Department of Human Services (WCDHS). These concerns were the result of complaints filed with the CPO, alleging general and systemic practice concerns by the WCDHS. In total, we received eight complaints involving six distinct families and 10 children. The agency reviewed child welfare and court documentation in these cases and ultimately identified 64 potential violations of state regulation and law. These potential violations included concerns about WCDHS' ability to assess child safety concerns, develop appropriate interventions for families and attempts to keep families intact. The CPO urged CDHS to do a systemic review of WCDHS' practices including speaking with children and families directly about their experiences with the WCDHS practices. Six months later CDHS stated it did not identify any pervasive practice issues and refused to interview any children or families involved in the cases. While the CPO was disappointed by the quality of the CDHS' review, the CPO continues to monitor cases from Washington County to ensure children and families are receiving fair and quality services.

Addressing Systemic Issues in Child Protection

State law requires the CPO to review systemic concerns in the Colorado child protection system. During the past fiscal year, there were several instances in which the agency highlighted the systemic issues impacting how child protection services are being administered in Colorado. For example, we presented four key issues to Colorado's Child Welfare System Interim Study Committee, which was seeking solutions to systemic barriers in providing care and protection for children in Colorado. The CPO highlighted the impacts of poor communication with parents, lack of systems to monitor caseworker misconduct, the absence of a quality assurance system for residential facilities and inconsistency in how departments assess the safety and risk of children. This work has transitioned into multiple pieces of legislation and ongoing work to address these issues.

Connecting with the Community

During the past fiscal year, we continued our efforts to connect with children and families to learn more about how the Colorado child protection system is functioning and to share more about our own work. Below are highlights from several of our efforts.

Tori Shuler Youth Voice Collective

The CPO was excited to launch its Tori Shuler Youth Voice Collective program during the past fiscal year. This program is dedicated to helping us connect with children, youth and young adults who have experience with the child protection system in Colorado. The CPO has continued to prioritize the experiences and expertise of children, youth and young adults in shaping its public policy initiatives and improving how it can deliver better services directly to this population. During its first year, we held more than a dozen listening and engagement sessions with youth. These sessions were dedicated to first, asking youth how we should approach establishing this program and, second, how the CPO can inform its practices to better serve them. Based on the information gathered during its first year, the Collective will be expanding its outreach and engagement during Fiscal Year 2024-25. This will include more in-person meetings, engagements in rural Colorado and youth-driven changes to the CPO's outreach materials and connection points.

Inaugural Youth Voice Event Celebration

On January 4, 2024, the CPO proudly partnered with the Office of the Child's Representative to host the first Foster Youth Voice Celebration. During the event 17 young people with lived experience in the foster care system were recognized for their leadership and advocacy in improving laws and policies in Colorado. More than 50 people attended the event, which included presentations by some of the young people being recognized. Judge Gail Meinster presented the young people with their certificates and the event was led by the mistress of ceremonies, Tori Shuler. Ms. Shuler was also recognized for her ongoing work and more than a decade of efforts to improve the foster care system in Colorado. The CPO coordinated with the Office of the Child's Representative and other state partners to host the event.

From left: Hon. Gail Meinster, Connie Vigil, Stephanie Villafuerte, Tori Shuler and Commissioner Charles Tedesco

National Presence

We are honored at the opportunities presented each year to expand the role of ombudsman offices across the country, and to support other ombudsman offices working to address the needs of children and families. Our team is deeply engaged with the United States Ombudsman Association (USOA), working to strengthen practice among the diverse public sector ombudsman across the country. During September 2023, CPO Deputy Ombudsman Jordan Steffen was elected to serve as president of the USOA. Our work with the USOA includes working to ensure ombudsman practice is infused with principles of diversity, equity and inclusion, as well as working to aid other ombudsman offices that are facing challenges to their role and authority. Members of our team presented information about ombudsman theory and the work of the CPO in more than half a dozen states during the past fiscal year.

CPO ADVISORY BOARD

The CPO Advisory Board is an independent, nonpartisan board comprised of 12 members. Four members are appointed from each branch of government and all members serve for a period of four years. Each position on the Board requires a certain amount of experience or expertise. The Board was established to provide a mechanism of oversight for the Child Protection Ombudsman, however, its role is much broader. The CPO team routinely relies on the expertise of its Board to expand and guide its work. Members have decades of experience and include child welfare professionals, judges, doctors, attorneys, county commissioners, human service directors, foster parents and advocates.

CPO BOARD OF DIRECTORS

Chief Justice Appointments
Benjamin Rounsborg, *Board Chair*
Hon. Gail Meinster
Hannah Seigel Proff
Katy Saehler

Governor Appointments
Judith Martinez, *Vice Chair*
Aaron Miltenberger
Connie Vigil

Senate President Appointment
Charles Tedesco

Senate Minority Appointment
Wendy Buxton Andrade

Speaker of the House Appointment
Dr. Coral Steffey

House Minority Leader Appointment
Brian Bernhard

ABOUT

OUR MISSION

Ensuring that the state's child protection system consistently provides high-quality services to every child, family and community in Colorado.

CPO STAFF

Stephanie Villafuerte, *Child Protection Ombudsman*
Jordan Steffen, *Deputy Ombudsman*
Karen Nielsen, *Director of Administrative Services*
Amanda Pennington, *Director of Client Services*
Paul Atkinson, *Communications Manager*
Bryan Kelley, *Public Policy Analyst*
Claire Hooker, *Client Services Analyst*
Morgan Baptist, *Client Services Analyst*
Abbey Koch, *Client Services Analyst*
Marcos Saldana, *Client Services Analyst*
Meredith Sullivan, *Client Services Analyst*

CONTACT INFORMATION

1300 Broadway, Suite 430, Denver, CO 80203

720-625-8640

coloradocpo.org

linkedin.com/company/cocpo

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CHILD PROTECTION OMBUDSMAN of COLORADO

July 30, 2024

1300 Broadway
Suite 430
Denver, CO 80203

720-625-8640

coloradocpo.org

ISSUE BRIEF

Surveillance Within the Division of Youth Services: How current efforts to monitor the use of physical restraints fall short.

In August 2023, staff at a Colorado Department of Human Services – Division of Youth Services (DYS) youth center moved to physically restrain a 13-year-old in their care. As staff attempted to force him down to the floor, his face slammed into a metal doorframe. The impact resulted in a gash on the youth's face that required a series of stiches to close. A written report prepared by the staff that restrained the youth stated the physical contact was necessary because the youth made verbal threats moments before.

Less than a year prior, a different youth at a DYS youth center was in a verbal disagreement with staff when he tossed items off a staff member's desk. Staff in the room moved to restrain the youth. One member utilized an unauthorized technique during the restraint. Again, the staff involved in the incident filed a report stating that the youth's verbal comments, and his failure to respond to verbal commands made by staff, warranted physical restraint.

Twelve months before that, during October 2022, a different youth was being closely monitored after experiencing a concussion at a DYS youth center. Medical professionals at the center had advised staff to avoid physical contact with the youth. However, staff ultimately used physical force to restrain the youth after, staff reported, the youth made verbal comments that warranted such a response. The youth, however, would later report that he had been antagonized by the staff with racist language.

In each of these cases, multiple entities viewed video of the physical force used to restrain the youth. The images on those videos helped them see how staff used different physical management techniques, how the youth was escorted out of a room or whether documentation accurately reflected the incident. But any determination that the use of force was justified was made without complete information. That is because the videos of each incident only captured images of physical contact. They did not include any audio recordings of the verbal exchange staff later claimed were cause enough to use physical force.

The use of physical force within DYS youth centers has been at the center of discussions in Colorado for more than a decade. In fact, during the past two fiscal years, the Office of the Colorado Child Protection Ombudsman (CPO) was contacted by 130 youth currently or formally residing in DYS facilities. In total, 25 percent of those cases concerned staff misconduct or the misuse of physical restraints – the majority of which were called in by youth themselves. DYS leadership, legislators, attorneys and families have long worked to decrease the use of violence in youth centers each year.[1] While various components of the issue have been addressed – including the use of mechanical devices and de-escalation techniques – physical restraints are still used today. During these physical restraints, youth have sustained broken bones, abrasions, concussions and broken teeth.

These case examples are a small sampling of the physical force used to restrain youth in DYS centers each year. While they are a small sampling, they represent a pervasive issue regarding the barriers in monitoring the safety and care of youth in such facilities. These concerns are compounded by data released by DYS that shows youth of color are more likely to be subject to the use of restraint or physical force. [2]

The CPO routinely receives cases that include the use of physical restraint on youth in DYS youth centers. In many of these cases, DYS staff claim that the reasons for physically managing a youth are because a youth made inappropriate verbal statements or threats, or alternatively, the youth refused to adhere to verbal commands made by staff. Like other entities in Colorado charged with reviewing such cases, the CPO has access to reports created by staff, surveillance videos from inside facilities and applicable protocols and laws. However, without audio recordings of these incidents, the CPO and other entities reviewing these cases have no effective way to determine if the use of physical force in these cases is justified. Without this ability, no one can provide meaningful monitoring or recommendations for improvement. Given these long-standing and escalating concerns, the CPO is recommending an overhaul of the existing surveillance systems to provide audio surveillance in addition to video surveillance as a means of improving facility security and the well-being of youth.

CURRENT SYSTEMS AND REVIEWS IN COLORADO

The CPO works to improve the state's child protection system. Within the agency's broad purview falls the DYS. [3] The CPO works with staff working in youth centers, youth residing in youth centers and those concerned about youth safety and well-being. The DYS posts materials about the CPO throughout youth centers, and youth have direct phone access to the agency. The CPO is also a named resource in both the youth and family handbooks.

During the past several years, the CPO has observed violent physical interactions between staff and youth in DYS centers. Through the agency's review of video surveillance, youth have been pushed into walls, shoved and thrown to the floor, sometimes, by multiple adults. Unfortunately, over time, the CPO has not seen a decrease in these types of cases.

The CPO works diligently to investigate the concerns brought to the agency. These cases involve a deep review of incident reports, grievance forms, medical documentation and video surveillance – as well as communication with the youth and youth center staff. Despite these efforts, the CPO continues to identify that the existing surveillance system within the DYS' youth centers is a barrier to adequately and thoroughly investigating complaints. This also impacts the quality of recommendations the CPO may make regarding policy or practice improvements regarding youth and facility safety.

Division of Youth Services

In Colorado, the Colorado Department of Human Services-Division of Youth Services (DYS) currently operates fifteen secure youth centers. [4] The DYS is responsible for the supervision, care and treatment of youth held in secure (locked and gated) settings pre- and post-adjudication, these are the juvenile or youth equivalents of adult jails and prisons.[5] The DYS also provides parole services to youth after commitment to a DYS youth center.[6] Youth who live in these facilities are not allowed to leave. While in these facilities, youth are assigned to a room, wear

[1] The CPO defines "staff misconduct" in these cases as distinct from physical restraints. Examples of possible staff misconduct include, intentional denial of services to youth, inequitable treatment, discrimination and inappropriate relationships between staff and youth.

[2] See DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024

[3] The Division of Youth Services is formally known as the Division of Youth Corrections

[4] Aspire Youth Services Center, Betty K. Marler Youth Services Center, Clear Creek Youth Services Center, Gilliam Youth Services Center, Golden Peak Youth Services Center, Grand Mesa Youth Services Center, Marvin W. Foote Youth Services Center, Platte Valley Youth Services Center, Prairie Vista Youth Services Center, Pueblo Youth Services Center, Rocky Mountain Youth Services Center, Spring Creek Youth Services Center, Summit Youth Services Center, Willow Point Youth Services Center, Zebulon Pike Youth Services Center

[5] DYS Key Terms identify a secure youth center as having locked doors, time-released locked panic bar door hardware, and/or secure perimeter boundaries to prevent youth from escaping.

[6] State of Colorado, Joint Budget Committee, DHS-OCYF Staff Figure Setting FY 2023-24

assigned clothing and are required to adhere to a strict schedule. Youth are separated from their families and communities and are dependent on the DYS for connection to the outside world.

Surveillance cameras are a standard feature in all juvenile facilities. The systems are designed to: (1) Detect and prevent specific behaviors such as contraband smuggling, self-harm and escape; (2) Facilitate the coordination of incident responses; and (3) Provide a training and accountability function for staff to ensure appropriate treatment of youth in the facility. Surveillance systems serve to protect both youth and staff from misconduct. It is common for youth in these facilities to be physically restrained when staff have made the determination that an emergency exists.[7] When a restraint happens, youth may be injured in the process. When this occurs, there are systems in place to assess whether protocols were followed and if the facts necessitating the restraint was accurately determined to be an emergency. To assess this, they often use video surveillance systems in addition to witness statements, medical records and incident reports to determine what occurred. Youth may face additional criminal charges as can staff for their misconduct.

DYS Physical Restraint Policy

DYS policy allows staff to use physical force and protective devices. The established policy notes that to ensure the safety of all youth in the care and custody of the DYS, and to prevent injury to youth and employees, that physical responses and protective devices may only be used in an emergency and after the failure of less restrictive alternatives.[8] Staff determine when an emergency exists and whether the youth is determined to be a serious, probable or imminent threat of bodily harm to themselves or others, and whether there is a present ability to affect such bodily harm.[9]

HISTORY OF THE ISSUE

Restraints at the Center of Reform Efforts

The use of physical restraints within DYS youth centers – and efforts to reduce the number of these incidents – has been the focus of many legislators, agencies and advocates for more than a decade. The impacts such restraints have on a youth's physical and mental health are well documented. These concerns received heightened attention in 2017, after the American Civil Liberties Union (ACLU) published its report, Bound and Broken. The investigative report highlighted how Colorado's DYS youth centers were contributing to a culture of violence for youth in their charge.[10] The report found that violence within the state's facilities had increased, that youth and staff reported feeling unsafe and that staff were routinely using force and pain tactics to control youth. The report recommended transforming the state's system to ensure that a culture of caring and true rehabilitation was available to one of our state's most vulnerable populations. It was also emphasized that transforming this culture would require a paradigm shift.

The release of the report spurred several legislative efforts to reform the DYS system. One such effort was the passage of House Bill 17-1329. The bill stated: "Fundamental cultural change is needed at the division [DYS] in order to provide for the safety of youths and staff and to effectuate real and lasting personal change for youths in the division's care."[11] The legislation instituted a number of requirements, including:

- Requiring the DYS to annually report recidivism rates and educational outcomes;
- Requiring the Office of the State Auditor review the reports to ensure accuracy and quality of reporting; and

[7] DYS Policy S-9-4, Security and Control

[8] DYS Policies, Chapter 9, Policy 9.4; Physical response is defined as "the physical action of placing hands on an individual in order to restrain movement. Any approved method or device used to involuntarily limit freedom of movement, including but not limited to bodily/physical force, or protective devices."

[9] C.R.S. 26-20-102; CDHS DYS Key Terms

[10] "*Bound and Broken: How DYC's culture of violence is hurting Colorado Kids and what to do about it*." Colorado Safety Coalition, ACLU, February 2017

[11] Colorado House Bill 17-1329

- Requiring the DYS to use a third-party agency to assess the DYS's de-escalation, physical management and safety policies and practices; as well as its provision of trauma-informed care.[12]

Although HB 17-1329 and additional legislation was passed to curb the use of restraints and further monitor the use of seclusion,[13] the CPO continues to have concerns regarding the experiences of those under the care of the DYS. Not unlike what was uncovered by the Bound and Broken report, the CPO continues to hear directly from youth about the injuries they have sustained because of being unnecessarily or excessively physically restrained, how it felt to be isolated from their peers or denied basic rights and services.

To truly understand if these efforts and others like them have improved the conditions and care provided to youth, additional consideration must be made to ensure entities like the CPO have all the information necessary. Presently, the widest gap in that information is the ability to review audio recordings of incidents to verify the accuracy of incident reports and personal narratives. Without this information, third-party reviewers have no way to independently assess whether the physical management was justified.

Similarities in Adult Corrections

While the CPO acknowledges that the DYS is not a traditional correctional system structure with law enforcement officers, in many ways they are more similar than not. For example, youth are housed in secure facilities and are dependent on DYS staff to meet their needs, including access to bathrooms, phones, visitors and medical care. Most importantly, DYS staff are permitted to use physical force and seclude youth. As discussed, many youth experience these incidents as excessive, unnecessary and traumatic. The CPO also believes that the adult correctional system and law enforcement communities have embraced the increase of surveillance devices and can provide the juvenile justice system with guidance and insight as to how they have undergone this transition. Throughout the last decade, the Colorado General Assembly has prioritized legislation that recognizes that enhanced surveillance is critical to creating transparency, accountability and trust in these systems.

In 2015, House Bill 15-1285 created a body-worn camera grant program for use with law enforcement agencies in Colorado, and a body-worn camera study committee. The body-worn camera study group examined best practices and published a report with their recommendation, citing that camera use is expanding for many reasons – evaluating and strengthening performance, enhancing transparency and accountability, and investigating and resolving complaints. Although the committee reviewed the use of body-worn cameras through the context of law enforcement use, the group study explained that officer safety and the safety of the public is of utmost importance when developing policies related to the cameras.[14] Additionally, the bill declared that the emergence of body-worn cameras within law enforcement settings had positive impacts on policing throughout the state and conveys the message that the actions of law enforcement are a matter of public record and concern.[15]

[12] Colorado House Bill 17-1329

[13] Colorado House Bill 16-1328

[14] Recommendations Regarding Body-Worn Camera Policies in Colorado, Pursuant to House Bill 15-1285, February 2016

[15] Colorado House Bill 15-1285

In 2020, Senate Bill 20-217 required all local law enforcement agencies and the Colorado State Patrol to issue body-worn cameras to their officers in specific settings. Officers must wear the body-worn cameras when they are performing a task that requires an anticipated use of force.[16] Again, the goal with this legislation was to enhance the integrity of law enforcement. And according to the Division of Criminal Justice, there has been approximately $5 million dollars spent on providing body-worn cameras to law enforcement agencies across the state.[17]

Through collaboration and innovation, the law enforcement community was able to identify a solution to transparency and trust issues. They then successfully scaled it to well over 200 agencies, across 64 counties. The CPO believes that this model provides a framework for a similar process to be done in the state's fifteen youth-serving facilities. The priority for youth safety would dictate that we do so.

ANALYSIS

During Fiscal Year 2023-24, the CPO was contacted by 70 youth who expressed concern for the treatment and care they received while living in youth centers. The CPO's cases include concerns regarding the use of a physical responses and protective devices.[18] Although the DYS is permitted to use physical force on a youth when determined appropriate, CPO clients often express concern regarding the amount of force used, particularly when youth are seriously injured.

The CPO's review of these cases demonstrated that, seven years after the Bound and Broken report was published, youth are still reporting instances of excessive force, poor treatment from staff and the misconduct of staff. Forty-seven clients reported concerns specific to excessive force and staff misconduct, this represents a 27 percent increase in the number of cases reported to the CPO the previous year.[19] Additionally, these issues are further exacerbated by the inadequacy of the existing surveillance systems to represent transparent and accurate depictions of interactions between youth and DYS staff.

Currently, DYS youth centers use a surveillance system that does not have audio capacity, meaning there is no record of what is being said by either party. The lack of audio availability is a barrier when attempting to review concerns of institutional abuse, child maltreatment and excessive force related to physical restraints. As such, the CPO has to piece together whether an incident between staff and a youth escalated and required a restraint. It is important to understand the incident in its entirety when reviewing these cases. Unfortunately, the CPO is currently unable to achieve this level of review because the DYS surveillance system only captures video of each incident. At best, this system provides half the information needed to assess these cases.

The remainder of the information comes from those who may have the most to lose by being forthright. Specifically, the incident reports created for each physical restraint are made by the staff members involved. These reports are often the only official document detailing what led to the use of physical restraints – effectively allowing the staff who utilized physical force the position to provide the only information that can establish whether the force was justified. In several cases reviewed by the CPO, the agency determined that staff who implemented a physical restraint to control a youth, did so after inaccurately determining an emergency existed. As a result, the youth was subjected to unnecessary restraint, trauma and, in some cases, injuries.

[16] See C.R.S. 24-31-902 (II)(D)

[17] See Colorado Department of Public Safety, Division of Criminal Justice, Body Worn Camera Funding: https://dcj.colorado.gov/body-worn-camera-funding

[18] See CDHS DYS Key Terms defines "Protective Devices" are devices used to involuntarily restrict the movement of a youth or the movement or normal functions of a portion of a youth's body; handcuffs, shackles, and transport belts are considered approved protective devices

[19] The CPO received 37 personnel/restraint related cases in FY 2022-23 and 47 similar cases in FY 2023-24.

Increased Need for Transparency and Care

During the past five years, the CPO has observed that youth living in youth centers have increasingly complex needs. It is common for youth in these settings to have mental and behavioral health needs, experience as victims of child abuse and neglect and/or be diagnosed with disabilities. The DYS reported that during the past two fiscal years the agency experienced the highest percentage of youth requiring mental health and substance use treatment, compared to the previous 16 years.[20] These youth need services and an environment capable of providing care and rehabilitation so that they may successfully return to their families and communities.

The CPO is charged with advising the public, legislators and stakeholders regarding systemic issues impacting the DYS. This includes families of youth who are residing, or resided, in a youth center. Without the CPO's ability to fully investigate complaints within the DYS, youth and families do not have true access to an independent review of their concerns. Through the investigation of these complaints, the CPO independently reviews case documentation, video surveillance footage, staff-generated incident reports and DYS Policy. The CPO has consistently observed discrepancies in staff and youth reports of these incidents, often involving incidents of physical responses. Because the current system lacks adequate surveillance, the CPO is unable to conclude whether verbal statements made by either party contributed to an incident or were in fact egregious enough to constitute an "emergency." Without audio, there is no definitive account of the events and/or resolution to the complaint.

Other agencies are also impacted by the lack of audio availability. Often, law enforcement and county human services departments are tasked with investigating assaults and allegations of child abuse and neglect within the DYS youth centers. In these instances, professionals must rely on witness statements from youth or staff, incident reports and video surveillance. It is common for these incidents to have been initiated because of a verbal altercation, threat or combination of non-verbal and verbal actions. Currently, there is no way for any agency reviewing these cases to independently confirm what the youth or staff communicated prior to a restraint.

Youth Support Additional Surveillance

Youth have expressed to the CPO that they would support improving the surveillance systems within the DYS youth centers as they believe that staff are aware of blind spots within camera systems and that staff use the lack of audio to make threats, disparage or intimidate them, which cannot be proven after the fact. Youth have expressed that better systems would provide them with a more equitable grievance process and that there may be a decrease in incidents of excessive force if there was a better accountability mechanism.

Legal professionals have expressed the importance of ensuring youth are properly advised of how the technology will be utilized. While some legal professionals have expressed concerns regarding youth confidentiality, the majority are supportive of expanded surveillance systems as a means to enhance youth safety. This is largely a result of their observations of an increase in excessive force incidents and the difficulty they have accessing incident reports and surveillance videos. These professionals have explained that it can take weeks or longer to work through these requests and the majority of the requests are denied, unless a subpoena has been granted requiring the information to be released. Of particular concern to these professionals is that in many of these scenarios, youth are often portrayed as the instigator and other professionals (magistrates, judges, district attorneys, parole board, therapists) may presume that the incident demonstrates the youth is unwilling to follow rules or comply with programming. These conclusions can dramatically impact a youth's future. There is little to no recourse for youth to challenge these presumptions. The CPO has yet to observe a case in which the DYS provides the court with information demonstrating the context or additional details for when a DYS staff has been found to have used excessive force or initiated a physical management without justification. This is often left to those professionals in defense roles, who are unable to obtain the records in time.

[20] CDHS DYS FY 2022-2023 Annual Report

Internal Review by DYS Shows Need for Audio Surveillance

Biannually, the DYS compiles and reports on data related to the statewide use of restraints and seclusion to the Youth Restraint and Seclusion Working Group (Working Group).[21] In the most recent report (which detailed incidents between March 2023 and August 2023), 465 unique youth experienced a restraint technique approximately 4,614 times.[22] To clarify, one youth may experience multiple restraints (techniques) within the review period.

Compared to the previous six-month review period (September 2022 to February 2023), there was a 10 percent increase in youth who were restrained, and a 34 percent increase in the number of restraint techniques used. Additionally, instances in which staff used physical force increased 37 percent. The use of mechanical restraints – such as handcuffs, shackles and belts – increased by 29 percent.[23] All of these methods are approved and designed to involuntarily restrict the youth's movement.

The DYS does not report on whether internal reviews of restraints found the use of force justified or whether injuries were sustained because of a restraint.

Black youth represent 38 percent of these restraints but make up 23 percent of the youth centers' population.[24] This is particularly troubling as it continues to demonstrate that youth of color and male youth are restrained more often.[25] The CPO's data also reflects this issue as the agency receives a disproportionate number of calls from youth of color.[26] Youth of color have reported to the CPO that they often deal with staff using racial slurs and language to provoke them. These youth believe that staff do this because there is no way to corroborate their use of offensive language on the surveillance footage.

In 2023, it was determined that the Working Group should continue to review the use of restraints and seclusion, as there are no other requirements for DYS to capture or report data related to the use of restraint and seclusion to the public. Additionally, without the requirement to provide such data, there would be no public forum for stakeholders to meet with DYS to discuss their concerns, learn more about the data being reported and request changes to the way data is reported and collected.[27]

The Division of Youth Services Quality Assurance (DYSQA/QAYS) also conducts compliance reviews and quarterly monitoring of the state's youth centers. This unit provides oversight to the DYS to make sure the facility runs safely. The DYSQA/QAYS conducts annual audits and monitoring visits to promote positive change in facilities and provide expertise regarding safety and security, clinical and medical services and training. Their purpose is to empower people and agencies with information and services to deliver high-quality programing to youth residing in youth centers.[28] However, there is little to no publicly available data about the work this unit conducts. Through a review of public information, the CPO was unable to locate any monitoring or annual audit reports, or redacted reports so that the public and those being served by the DYS could be informed of both the strengths and areas of improvement.[29]

The CPO is aware that the DYSQA/QAYS often reviews incidents involving the use of force and makes recommendations to improve practice. These recommendations, however, are not available to the public.

[21] See Colorado House Bill 15-1285, Youth Restraint and Seclusion Working Group; C.R.S. 26-20-110

[22] DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, inclusive of all restraint techniques

[23] DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, inclusive of all restraint techniques; a side hold temporarily immobilizes the youth's hand and feet

[24] DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, Aggregate Summary – Restraint Techniques

[25] DYS Restraint and Seclusion Working Group Semi-Annual Report, Published January 2024, Aggregate Summary – Restraint Techniques

[26] In the FY 22-23, 25 out of 58 CPO youth client identified themselves as a race other than Caucasian.

[27] Colorado Department of Regulatory Agencies, 2023 Sunset Review Report, Published October 13, 2023.

[28] See Colorado Department of Human Services, Division of Youth Services Quality Assurance: https://cdhs.colorado.gov/dysqa

[29] DYSQA and DYS Office of Quality Assurance

Prioritizing Improvement

The CPO has met with the DYS consistently over the last two years to discuss CPO cases, DYS data and concerns related to the adequacy of the surveillance system. The DYS acknowledges the CPO's concerns for the agency and other agencies with similar concerns. Repeatedly, the DYS has stated two main reasons that enhancing the surveillance system has not taken place.

- First, that systems requiring staff to wear body-worn cameras do not align with the DYS' trauma-informed approach they are working to maintain. This is largely because DYS believes that this type of approach has the tendency to pit youth and staff against each other.
- Second, equipping the state's youth centers and staff with a new surveillance system that allows for the review of audio recordings is financially prohibitive.

The CPO has continued to suggest alternative options such as equipping new facilities with current whole surveillance technology that encompasses both audio and video, so that facilities are not left to piecemeal their systems together with left over money from their budgets. Despite this recommendation, and millions of dollars spent during the past several years on new facilities and ongoing facility upgrades, audio surveillance has not been prioritized.

The decision not to prioritize updated surveillance systems in Colorado, sits in contrast to agencies in other states facing similar constraints. During the past decade, agencies in other states have not only prioritized the change but have found the ability to review audio recordings has contributed to a decrease in violence. Some examples include.

- Ohio: the Indian River Juvenile Correctional Facility implemented body-worn cameras in its facility after a 2022 incident in which 12 youth barricaded themselves in the facility due to ongoing complaints and concerns about the conditions and safety within the facility. [30] A year after implementation, the facility reported a 31% decrease in violence against staff and an almost 40% decrease across the three-facility campus.[31] The facility partially attributed a decrease in violence due to the introduction of body-worn cameras.
- Louisiana: Youth services implemented body-worn cameras in juvenile correctional facilities in 2022. The policies outlining their use explained that the purpose for the increased surveillance is to provide for enhanced transparency and accountability in interactions between staff and youth, noting that staff's entire shift will be recorded, and that the camera will record and store both audio and video.[32]
- Wisconsin: In 2015, a Wisconsin juvenile detention center implemented body-worn cameras after several reports of abuse by staff. [33] The facility and Division of Juvenile Corrections also completed a review of technology to ensure that there was broader monitoring and recording of surveillance footage, and installed additional video cameras in critical areas and implemented a "comprehensive camera upgrade project." Staff explained that these steps allowed them to make youth safety a top priority.

Conversely, during the past two fiscal years in Colorado, the DYS has built new youth centers, remodeled older centers and made small technical upgrades to facilities throughout the state. In each instance, the DYS elected to install or repair systems that lack the capacity to capture audio.

[30] See "Ohio juvenile facility deploying bodycams after barricade" Megan Sims, Cleveland.com: October 24, 2022, Distributed by Correctsions1 Newsletter

[31] Response to safety incidents include deploying body-worn cameras on staff, retraining staff on verbal de-escalation techniques, among others. https://www.news5cleveland.com/news/local-news/we-follow-through/staff-attacks-havent-stopped-at-indian-river-juvenile-correctional-facility-per-union-president

[32] State of Louisiana, Office of Juvenile Justice, C.2.C.2.30, Field Operations, Security, Body Cameras

[33] See "Reports of Juvenile Inmate Abuse Prompts Prison to Adopt Body Cams" Matthew DeFour, The Wisconsin State Journal, December 15, 2015, Distributed by Government Technology

CONCLUSION AND RECOMMENDATION

Youth living within Colorado's DYS youth centers deserve to be kept safe. When they have concerns about their safety or how they are being treated, they have a right to have those complaints heard by an independent agency. These complaints highlight the daily experiences of vulnerable youth and can often help identify trends or areas for system improvement.

Despite the recommendation in Bound and Broken for increased youth safety and public transparency, the system has not gone far enough to improve the experience and living conditions for youth in Colorado's secure youth centers. Through the CPO's work and the work of other agencies, the inadequacy of the surveillance system has highlighted that the system does not have the resources to adequately review incidents of concern, make timely and appropriate recommendations to improve the safety and experience for youth, or a transparent mechanism to understand safety in each facility.

Even when building new youth centers, remodeling older ones and making smaller technical upgrades, the DYS has consistently chosen to install or repair systems that lack the capacity or potential for audio.

The CPO makes the following recommendations:

1. The DYS overhaul the existing surveillance system to include comprehensive audio and video coverage throughout the facilities.
2. The DYSQA/QAYS identify a public reporting mechanism to share information learned regarding their monitoring visits, annual audits and individual incident reviews on a consistent and recurring basis.
3. The DYS provide the Youth and Seclusion Working Group with additional data, including the following:

   a. The number of restraints determined to be justified and the number of restraints determined to be unjustified. For each determination, the data should include information explaining the basis and rationale for the determination.

   b. The number of times a youth sustains serious bodily injury during a restraint.

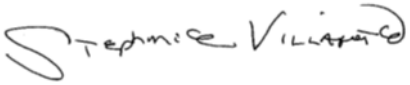
   c. Youth race and ethnicity information related to recommendations 3(a) and 3(b).

Without the availability of audio surveillance in combination with video surveillance, these complaints cannot be fully reviewed by agencies such as the DYS, law enforcement, county human services departments and the CPO. The CPO is hopeful that the child protection system will take a meaningful and key step toward improving transparency within DYS youth centers and prioritizing the safety and experiences of youth in its care.

Pursuant to C.R.S. 19-3.3-103(2), the CPO respectfully submits this report to the citizens of Colorado, child protection stakeholders and the Colorado General Assembly.

Amanda Pennington

Director of Client Services



Stephanie Villafuerte

Child Protection Ombudsman

EXECUTIVE SUMMARY

Timothy Montoya Task Force Final Report

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER

Colorado provides out-of-home care for some of Colorado's most vulnerable youth.

This includes youth who are placed in our state's foster care system as well as those youth who are placed in the state's 24/7 residential care facilities for treatment of their severe behavioral health needs.

Ideally, these placements are designed to keep children safe while they are receiving shelter, necessities, treatment and care. However, the reality is that youth run from these placements each year and Colorado has no standardized statewide system in place to prevent them from running, protocols to actively locate them while they are gone nor a standard process to provide consistent care for them when they return. The result is that Colorado is responsible for thousands of children in its foster care and behavioral health care systems and yet, these youth can leave without adult care or supervision for days, months or perhaps longer. In some instances, youth never return at all—as was the case with 12-year-old Timothy Montoya who died in June of 2020, after he left his therapeutic facility and was hit and killed by a car.

In response to Timothy Montoya's death the Colorado General Assembly passed House Bill 22-1375, "Child Residential Treatment and Runaway Youth," which established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-Of-Home Placement. This task force explored the challenges associated with youth who run from care and worked to create a consistent, prompt and effective response to youth who run away from their out-of-home placements.

The task force was charged with analyzing and making recommendations to the General Assembly on how to improve the state's laws, regulations and practices. There were several specific directives that the task force was required to address.

The task force now issues its final report. The recommendations of the task force are presented in their entirety following the order set forth in the legislation authorizing the task force. Since the final report is organized around the directives set forth in the legislation, it does not convey the overall spectrum of changes being recommended by the task force.

In sum, the task force found that there is no cohesive, statewide system in place that addresses the needs of youth who run from out-of-home placements. This summary document presents the recommendations of the task force across three distinct categories to show how they are designed to work together and create a continuum of services for youth who run from out-of-home placements.

For the full text of all recommendations please refer to the task force's final report.

Creating a Continuum of Services for Youth Who Run from Out-of-Home Placements

As the task force considered the issues, the group identified a system of care that addresses run away incidents at three levels: **Prevention**, **Intervention** and **After-Care**. These recommendations are summarized as follows.

Prevention: Preventing Youth from Running from Care

The task force recognized that an ideal system to reduce instances of youth running from out-of-home care would need to place a special emphasis on prevention efforts. Many issues currently arise in Colorado which could be avoided or mitigated. This group of recommendations would work together to ideally prevent youth from running from care in the first place, thereby eliminating the risks associated with running from care.

› Create a Standard, Statewide Database for Youth Who Run from Care

The state of Colorado currently has very little data about youth who run from care. This means that we often do not know what leads youth to run from care, what they experienced when they were away or how best to help them when they return. These recommendations would create a statewide data collection system that would both help us to better understand trends across the state as well as how to best help individual youth. See Recommendations 1A and 1B.

› Create a Runaway Prevention Curriculum for Care Providers, Foster Families, and Youth

There is currently no standard, required education for youth or caregivers on the risks of running away from care, or the services available to youth to help them return to care. The task force considered educational programs that already exist, such as the National Runaway Safeline's materials that include resources and services for those seeking support. These recommendations would create standard, required education for both youth and those providing them with care. See Recommendations 6D and 6E.

› Analyze Facility Security and if Necessary, Add Additional Safety Measures to Deter Youth from Running from Care.

Some facilities have physical infrastructure – such as locks, fencing, and alarms – to prevent youth from running, but many do not have this hardware or even know if it is allowed. This has led to a situation where youth are often able to simply walk away from care without any barriers. These recommendations would survey facilities, assess their needs, ensure facilities are appropriate for the care of youth, and if necessary, provide funding to implement trauma-informed mechanisms to keep youth from running from care. See Recommendations 6A and 6B.

› Develop a Standard Pre-Admission Risk Assessment Tool that Measures the Likelihood that a Youth Will Run and the Risks They Face.

When a youth is admitted to an out-of-home placement, facilities and foster families have no way of knowing their likelihood of running or the unique risks they may face if they were to run. As a result, there is often little to no information to inform how to respond to a youth who runs from care. This recommendation would develop a tool to assess youth soon after they begin their entry into foster care or residential treatment, helping to ensure that the youth receive appropriate care and participate in run-prevention efforts if necessary. See Recommendations 6C.

› Clarify in State Law when a Facility May Intervene to Prevent Run Away Behavior

Task force members found that there is ambiguity in the law and state regulations about a facility's ability to prevent a youth from running from care. As such, youth are often allowed to leave the premises without any intervention by facility staff. These recommendations will help bring clarity to the law so that staff know when, how and under what circumstances they may prevent a youth from leaving care. See Recommendations 5A, 5B and 5C.

› Require Notification to Parents and Caregivers on Facility Policies and Protocols on Preventing Youth from Running from Care

Placing a youth in out-of-home care has tremendous implications for a child's well-being.

Currently, there is no requirement for residential facilities to provide their policies on what interventions they will take to prevent a youth from running. This recommendation would both require facilities to inform caregivers of their policies and give caregivers the option to sign a waiver allowing a facility to intervene when a youth runs from care. See Recommendation 5D.

Intervention: Responding When a Youth Runs from Care

The task force learned that there are many reasons a youth will leave an out-of-home placement. These include disconnection from their biological families, behavioral health and emotional dysregulation associated with prior trauma. The task force sought to ensure that, when a youth does run away from care, a system exists to ensure there is an efficient, well-structured and trauma-informed effort to recover them.

› Create Statewide Protocols and Tools That Ensure Every Missing Youth Is Responded to in a Timely and Effective Matter.

In Colorado state law, there are few requirements about what must be done when a youth runs away from care. This often leads to inconsistent response strategies and can sometimes mean that there is no plan in place to recover youth who have run. These recommendations would help create a system where a designated group of specialists would utilize specific risk categories to determine how to best respond to youth missing from care and ensure they are safely returned. See Recommendations 3A, 3B, 3C, and 7A.

After-Care: Ensuring that Youth who Leave Care Receive Appropriate Medical and Mental Health Evaluations and Care

A lot can happen to a youth when they have run from care, and they may have new needs that did not exist prior to their departure. Once a youth is recovered, it is crucial that they be given appropriate care to not only ensure their well-being but to prevent future run attempts from occurring.

› Create Short-Term Stabilization Units for Youth to Assess Appropriateness of Current Placements and Return Plan for a Youth

Once a youth has run from out-of-home placement, there may be nowhere for them to return to because their original placement was not appropriate, or their placement may not have been held during their absence. Sometimes youth who have run are instead forced to reside in hotels or even office buildings while a new placement is found. This recommendation would develop short-term stabilization units where youth could receive appropriate, short-term care while longer-term placements are arranged for them. See Recommendation 5E.

› Develop a Standard Post-Run Recovery Tool

Youth who run from out-of-home placements may have traumatic experiences while away from care or may be returning to an environment from which they still want to run. Currently, there is no standard practice for asking a youth why they have run, what their experiences were while away, or if anything could be done to make them more likely to stay. There is also no standard practice and protocols for assessing a youth's physical and psychological well-being upon return. As a result, a youth's needs are often not addressed, and they may be just as likely to run a second time. This recommendation would develop a standard post-run recovery screening tool to ensure the youth receives proper care. See Recommendation 6C.

CONCLUSION

The Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement is proud to submit this executive summary and its final report to the Colorado General Assembly, the Office of the Governor, and the people of Colorado. The task force recognizes the tragedies that too often occur when youth run away from out-of-home care and into unsafe circumstances. Task force members sincerely hope that these recommendations will help to establish a statewide system that will avoid such future tragedies through preventing runs, intervening when they do occur, and taking care of youth once they have been recovered.

FINAL REPORT SNAPSHOT

Mandatory Reporting Task Force Final Report

Introduction

Mandatory reporting is the requirement for people in certain occupations to make a report if they have a suspicion that child abuse or neglect is taking place. The Colorado legislature created the Mandatory Reporting Task Force to issue recommendations on how to improve the state's mandatory reporting policies. The task force has just released its **final report**, which can be found **here**.

Problem

The task force was asked to clarify existing law as well as make recommendations that would address and decrease the overrepresentation of under-resourced communities, families of color and people with disabilities in the child welfare system. The goal of the task force was to create an equitable mandatory reporting system that ensures the protection of children.

The Task Force's Recommendations and Responses Revolve Around the Following Themes:

1

Recognizing and Addressing the Disproportionate Impacts of Mandatory Reporting Law and Policies

2

Clarifying Reporting Processes and Requirements

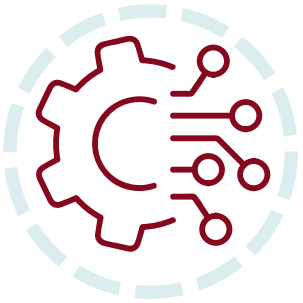
3

Creating and Requiring Mandatory Reporter Training

4

Addressing Requirements for Specialized Occupations

5



Reviewing and Improving Data and Information Systems

FINAL REPORT SNAPSHOT

Solution

The Mandatory Reporting Task Force's final report contains recommendations to create a system that better – and more equitably – serves Colorado's children, families and communities.

Recognizing and Addressing the Disproportionate Impact of Mandatory Reporting Law and Policies: The task force analyzed the effectiveness of mandatory reporting, crafted recommendations to address and reduce its disproportionate impacts on certain communities, and recommended what should be done if a family would benefit from services rather than an abuse or neglect report.

Clarifying Reporting Processes and Requirements: The task force created recommendations addressing a mandatory reporter's timeline for reporting, whether they must report outside their professional capacity, whether joint reports can be made, whether a reporting duty can be delegated to someone else and whether places like hospitals and schools can create their own institutional policies.

Creating and Requiring Mandatory Reporter Training: Four recommendations address mandatory reporter training, including whether training should include details about the law, standardized teachings about implicit bias, information on how counties determine thresholds for assessment and investigation, and what requirements should exist for licensed professionals.

Addressing Requirements for Specialized Occupations: The task force also addressed reporting requirements for those creating safety plans for victims of domestic violence, sexual assault, or stalking; those working for attorneys; and those professionals addressing medical child abuse.

Reviewing and Improving Data and Information Systems: These recommendations address what personal information of children is collected, the potential benefits of an electronic reporting platform, and processes for sharing information between agencies and to mandatory reporters.

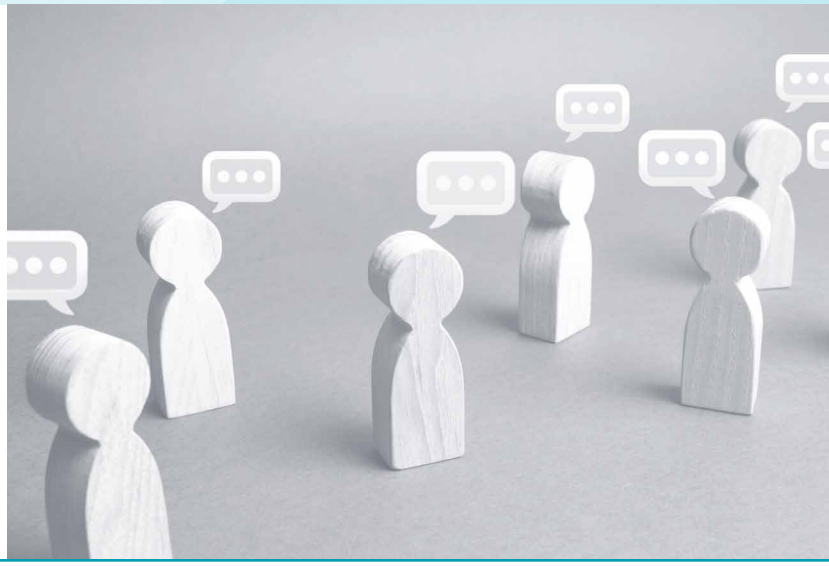
Questions?

If you have any questions about the task force or its final report, please contact:

Stephanie Villafuerte
Colorado's Child Protection Ombudsman
svillafuerte@coloradocpo.org › 720-625-8641

Jordan Steffen
Deputy Ombudsman
jsteffen@coloradocpo.org › 720-625-8645

Bryan Kelley
Public Policy Analyst
bkelley@coloradocpo.org › 720-673-9546



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 service 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 to create a better child protection system now and for the future.

CHILD PROTECTION OMBUDSMAN of COLORADO

KEYSTONE POLICY CENTER