CHILD PROTECTION OMBUDSMAN of COLORADO

Office of the Colorado Child Protection Ombudsman

Fiscal Year 2023-24 Annual Presentation
Joint Health Committee

January 18, 2024

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 1,119 contacts in FY 2022-23, resulting in a 14% increase from previous fiscal year
- 80% increase in the number of cases initiated by youth
- Cases are increasingly complex and require more attention and time
- Average annual growth rate of 18%
- Currently, the CPO anticipates opening approximately 1,563 cases in FY 2024-25.

CPO Case History	Total # of Cases
Fiscal Year 2022-23	1,119
Fiscal Year 2021-22	982
Fiscal Year 2020-21	852
Fiscal Year 2019-20	725
Fiscal Year 2018-19	575

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.

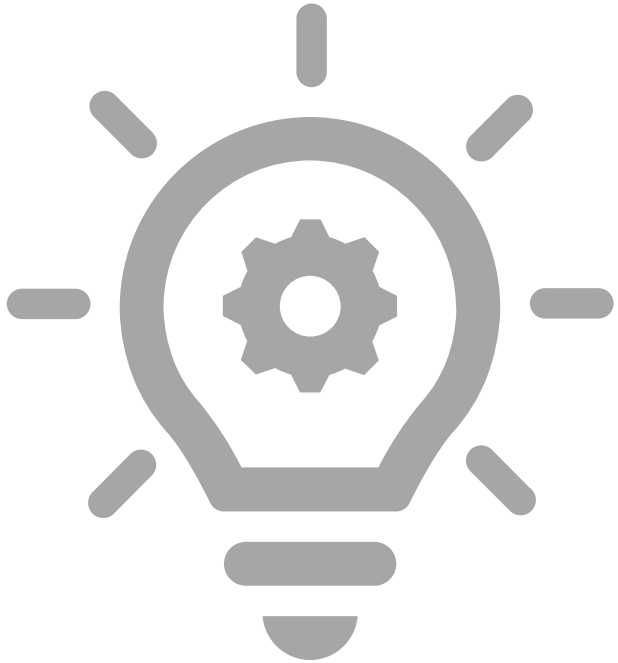
- **SYSTEMIC CHANGE:** Collaborate with youth, caregivers, stakeholders and policy makers to advance improvements to child protection services, policies and laws for every community in Colorado.

Community Outreach

- Promote awareness of the CPO among children, youth and young people with lived experience in the child protection system.
- Promote awareness of the CPO among communities of color to increase equitable access to for youth and families disproportionately involved in Colorado's child protection systems.
- Promote awareness of the CPO among rural communities to increase equitable access to services for every community, county and region in Colorado.
- 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.

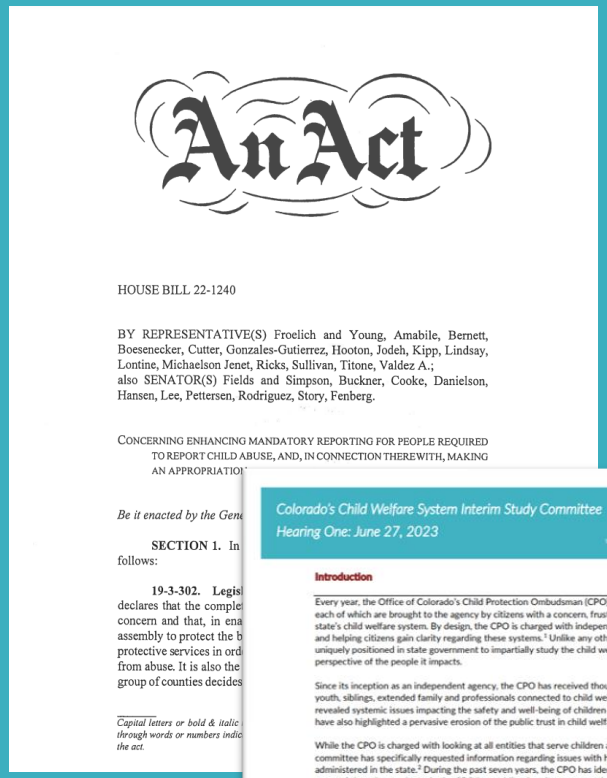
Services and Programs

- Provide CPO staff with ongoing education and training.
- Continue to develop efficient and impactful case practices.
- Develop and implement a unique, research-informed process for reviewing critical incidents in Colorado to improve and advance child protection system.



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 & Families.
- Serve as an independent, neutral and objective resource for legislators on child protection issues.



An Act

HOUSE BILL 22-1240

BY REPRESENTATIVE(S) Froelich and Young, Amabile, Bernett, Boesenecker, Cutter, Gonzales-Gutierrez, Hooton, Jodeh, Kipp, Lindsay, Lontine, Michaelson Jenet, Ricks, Sullivan, Titone, Valdez A.;
also SENATOR(S) Fields and Simpson, Buckner, Cooke, Danielson, Hansen, Lee, Pettersen, Rodriguez, Story, Fenberg.

CONCERNING ENHANCING MANDATORY REPORTING FOR PEOPLE REQUIRED TO REPORT CHILD ABUSE, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATIO

Be it enacted by the Gene

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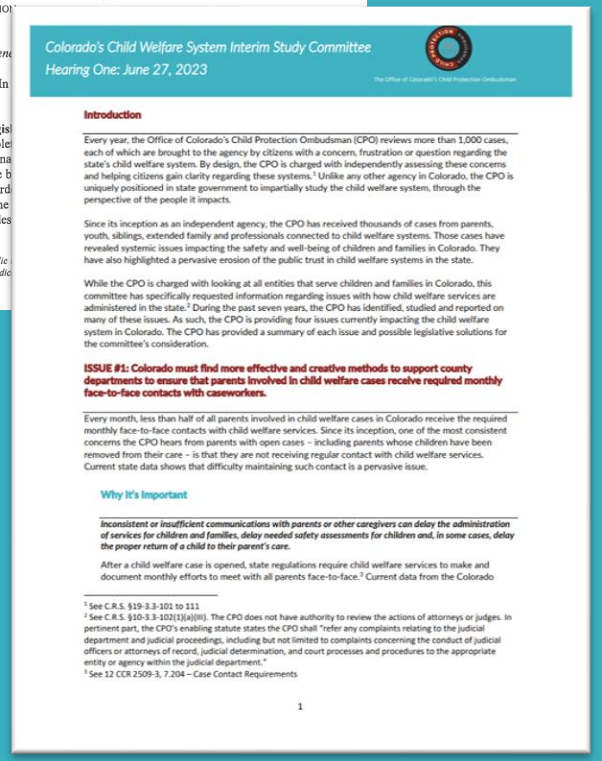


Colorado's Child Welfare System Interim Study Committee
Hearing One: June 27, 2023

The Office of Colorado's Child Protection Ombudsman

Introduction

Every year, the Office of Colorado's Child Protection Ombudsman (CPO) reviews more than 1,000 cases, each of which are brought to the agency by citizens with a concern, frustration or question regarding the state's child welfare system. By design, the CPO is charged with independently assessing these concerns and helping citizens gain clarity regarding these systems.[2] Unlike any other agency in Colorado, the CPO is uniquely positioned in state government to impartially study the child welfare system, through the perspective of the people it impacts.

Since its inception as an independent agency, the CPO has received thousands of cases from parents, youth, siblings, extended family and professionals connected to child welfare systems. Those cases have revealed systemic issues impacting the safety and well-being of children and families in Colorado. They have also highlighted a pervasive erosion of the public trust in child welfare systems in the state.

While the CPO is charged with looking at all entities that serve children and families in Colorado, this committee has specifically requested information regarding issues with how child welfare services are administered in the state.[3] During the past seven years, the CPO has identified, studied and reported on many of these issues. As such, the CPO is providing four issues currently impacting the child welfare system in Colorado. The CPO has provided a summary of each issue and possible legislative solutions for the committee's consideration.

ISSUE #1: Colorado must find more effective and creative methods to support county departments to ensure that parents involved in child welfare cases receive required monthly face-to-face contacts with caseworkers.

Every month, less than half of all parents involved in child welfare cases in Colorado receive the required monthly face-to-face contacts with child welfare services. Since its inception, one of the most consistent concerns the CPO hears from parents with open cases – including parents whose children have been removed from their care – is that they are not receiving regular contact with child welfare services. Current state data shows that difficulty maintaining such contact is a pervasive issue.

Why It's Important

Inconsistent or insufficient communications with parents or other caregivers can delay the administration of services for children and families, delay needed safety assessments for children and, in some cases, delay the proper return of a child to their parent's care.

After a child welfare case is opened, state regulations require child welfare services to make and document monthly efforts to meet with all parents face-to-face.[3] Current data from the Colorado

[1] See C.R.S. §19-3.3-101 to 111
[2] See C.R.S. §10-3.3-102(1)(a)(III). The CPO does not have authority to review the actions of attorneys or judges. In pertinent part, the CPO's enabling statute states the CPO shall "refer any complaints relating to the judicial department and judicial proceedings, including but not limited to complaints concerning the conduct of judicial officers or attorneys of record, judicial determination, and court processes and procedures to the appropriate entity or agency within the judicial department."
[3] See 12 CCR 2509-3, 7.204 – Case Contact Requirements

1

INVESTIGATIONS

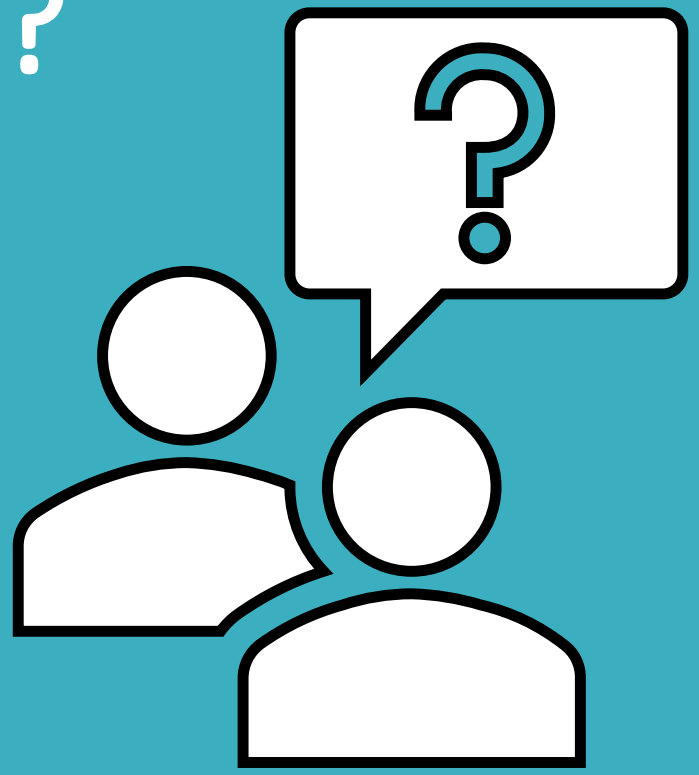
State calls for review of years worth of child welfare cases in Washington County

Review suggests that staff at WCDHS held negative opinions of parents, which sparked a request by the State Ombudsman to review all cases between 2018-2022.

Highlights to Date

Where We Are Heading

QUESTIONS?



OFFICE *of* COLORADO'S

CHILD PROTECTION OMBUDSMAN

ANNUAL REPORT

FISCAL YEAR 2022–23

LISTEN **INVESTIGATE** **RESOLVE** **IDENTIFY TRENDS** **LASTING CHANGE**

LETTER FROM THE OMBUDSMAN

Dear friends and community partners,

I am honored to present the Office of the Colorado Child Protection Ombudsman's Fiscal Year 2022-23 Annual Report. The Colorado General Assembly created the CPO to provide a unique service to the citizens of Colorado. Unlike any other agency in the state, the CPO is specifically designed to serve as an impartial, free and creative resource for the children, families and professionals involved with the child protection system. Our charge is broad. In addition to helping citizens one-on-one address their concerns and questions, this agency is also tasked with studying and improving systemic issues impacting children and families in Colorado. While this agency has only existed in its current form for seven years, the demand for our services continues to grow and our impact continues to reach new depths.

The CPO transitioned into an independent state agency only seven years ago. Since that transition, we have grown from three employees to 11 full-time employees, two contract positions and multiple program areas. This growth has been necessary to meet the steady increase in the number of cases coming into the CPO, as well as the increasing systemic projects and programs brought to the CPO. In fact, the CPO had its fourth consecutive record-setting year. During the past fiscal year, the CPO opened an unprecedented 1,119 cases – a 14 percent increase from the previous year and 94 percent increase from the agency's first fiscal year as an independent agency.

During this fiscal year, in addition to continuing the agency's focus on customer service, we have continued to prioritize our outreach to youth in Colorado. The CPO was contacted by youth a record 72 times during FY 2022-23. Additionally, we have obtained funding and assistance to expand our direct youth outreach efforts and we will continue to work with youth directly and community partners to ensure youth in Colorado who need our services are easily able to access them. We have also continued to expand and refine our work to address questions and concerns regarding systems that closely interact with the child welfare system, including behavioral health services, residential services, early childhood services and others. Much of this work is highlighted in this report.

Our ability to dig into more than 1,000 cases a year gives us a lens into the child protection system that no other state agency has. Through this lens, we are able to identify issues impacting how services are delivered. Through our position in state government, we are able to take innovative and inclusive approaches to addressing such concerns. The CPO's Policy Collaborative for Children & Families has continued to serve as a unique space in Colorado to address long-standing issues. This year we were proud to house the Mandatory Reporting Task Force (established through House Bill 22-1240) and the Timonthy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placements (established through House Bill 22-1375). These multidisciplinary task forces are each composed of dozens of stakeholders and will address a collective 28 directives—each with the potential to reform and/or improve practices that have existed for decades. These two task forces are emblematic of our dedication to fostering inclusive and smart conversations regarding child protection in Colorado.

The CPO's success is due to the efforts and ingenuity of a strong and diverse team, and the continued support and guidance of the CPO Advisory Board. As we reflect on the past fiscal year—and look forward to the work ahead—we know there is much to be done. However, we are confident that we will continue to refine our skills and expand our reach so that every citizen who contacts this agency receives thorough and thoughtful services.

Sincerely,

Stephanie Villafuerte

Stephanie Villafuerte
Colorado Child Protection Ombudsman

CONTINUED GROWTH

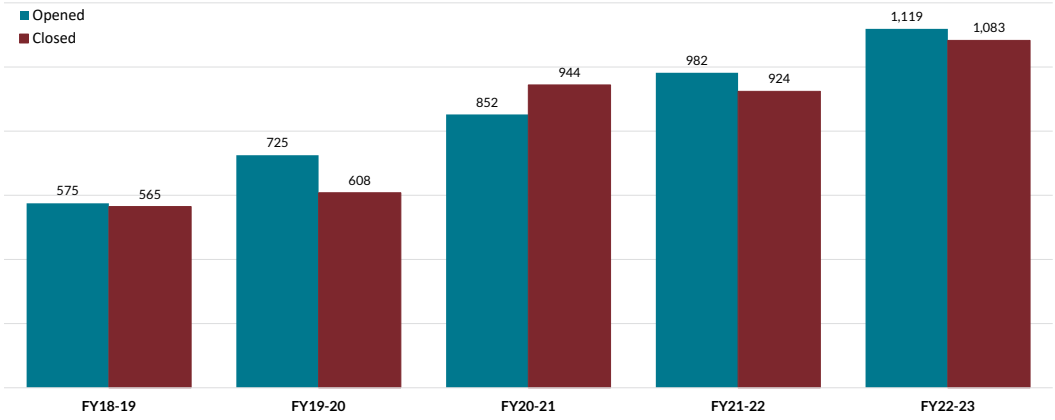
CPO CASES IN FY 2022-2023

Opening a record number of cases for the fourth consecutive year, our agency received 1,119 contacts from people seeking help during Fiscal Year 2022-23. This 14 percent annual increase not only reflects the growing role of the Office of the Colorado Child Protection Ombudsman (CPO) in supporting youth, families and communities but demonstrates the benefits of our unprecedented outreach efforts and public policy initiatives. We also closed a record 1,083 cases during the fiscal year, marking a 17 percent increase compared to the previous fiscal year. Of the cases closed by our agency, two-thirds were opened by caregivers—94 percent of which were birth parents, relatives or siblings to the children involved in the case. The largest area of growth in case closures was among those initiated by youth. Our agency closed a total of 68 cases from youth which was a 74 percent jump from the previous fiscal year.

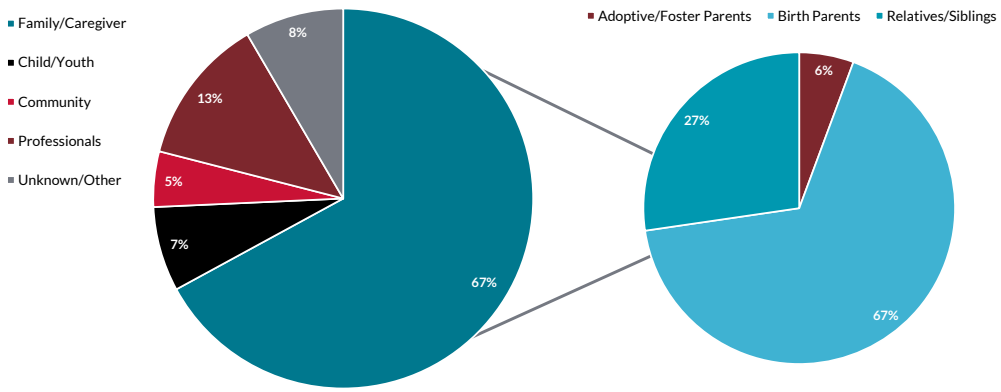
CPO CASE HISTORY	TOTAL # OF CASES
Fiscal Year 2022-23	1,119
Fiscal Year 2021-22	982
Fiscal Year 2020-21	852
Fiscal Year 2019-20	725
Fiscal Year 2018-19	575
Fiscal Year 2017-18	611
Fiscal Year 2016-17	577

Of the cases closed by our agency in FY 2022-23, 30 percent involved concerns regarding how child welfare services handled reports of abuse and neglect. Access to services and personnel issues were the second and third-highest concerns—appearing in 21 and 19 percent of cases, respectively. Additionally, the CPO continued working with the Devereux Colorado Unaccompanied Children's Service Program, to review the care provided to unaccompanied immigrant children placed in licensed facilities in Colorado. However, on March 16, 2023, the CPO was notified that Devereux was ending this program, citing concerns recruiting and retaining bilingual staff. The program discharged all clients by the end of March 2023.

CASES BY FISCAL YEAR



RELATIONSHIP TO CHILD



CASE HIGHLIGHTS

Case #1

The CPO was contacted by a youth who was residing in foster care. The youth shared concerns that her 17-year-old foster sister was not allowed to drive herself or her five siblings around due to Colorado's young driver laws. The youth explained that drivers under 18 in Colorado cannot drive with more than one passenger in the car unless the passengers are members of the driver's immediate family. The youth was told that, as a youth in foster care, she didn't count as part of the immediate family, which made her feel excluded from the family. The CPO researched the law and spoke with a representative from the Colorado Department of Transportation (CDOT). CDOT clarified that foster siblings are considered immediate family. The CPO shared this information with the youth and made sure to clarify that if her foster parents had certain rules regarding who she may drive in the car with, those need to be followed. The youth was happy to hear that CDOT included youth in foster care in the definition of family and the youth said that she was thankful for the CPO's help. The youth's foster mother reported that they were excited to learn this information and the youth's experience advocating for herself was positive. The CPO also provided contact information for Project Foster Power if the youth would like to explore other advocacy opportunities.

Case #2

A citizen contacted the CPO with concerns that a county department of human services did not properly notify the judge overseeing the child's court case. The citizen was concerned the judge was not providing important child safety and parent information throughout the child welfare case. This included information about the circumstances in the foster home where the child was living. Without this information, the citizen alleged, the judge was not able to make informed decisions regarding the child's care. The CPO reviewed relevant documentation and identified concerns regarding the level of detail provided in court reports. The reports did not contain information about new referrals of abuse or neglect. The CPO also identified that the county department did not address safety concerns with the foster home and had additional questions as to why the foster home's certification history was irregular. The CPO facilitated a meeting with the county department who affirmed the CPO's concerns. Regarding the lack of information on about new referrals in the foster home, the agency stated it had received guidance from their legal counsel that sharing information could breach the confidentiality of the foster care providers. The county department also shared that they agreed that they did not address safety concerns in the foster home timely. They reported that this was because they believed it was the responsibility of a neighboring county department, because this is where the family lived.

CASE HIGHLIGHTS

Case #3

During December 2022, the CPO was contacted by a young adult who had been placed in a residential child care facility (RCCF) and group home as a youth. The young adult stated they needed a letter to verify they had been in foster care to obtain education benefits. The young adult said that the county department involved in her case, told her it would take up to 30 days to get the letter. Unfortunately, the young adult was running up against a deadline to submit her materials. The CPO contacted the county department, who responded immediately and stated that they were unable to locate the documentation showing the young adult was ever in foster care. The CPO facilitated communication between the young adult and the county department, and it was determined that although they were placed in an RCCF and later a group home, they were never in the county department's custody. The county department did complete child welfare assessments regarding the young adult and their family, and there was a juvenile delinquency case through the courts, but there was neither an ongoing child welfare case nor a dependency and neglect case. It appeared that the young adult had been placed through Medicaid or private pay. The CPO explained this information to the young adult, and the county department said they would also call them the same day. Although the county department was not able to provide the requested documentation, they were quick to refer the young adult to a community resource that provides support to individuals who have previous experience with juvenile delinquency courts.

Case #4

A grandmother caring for her grandchildren contacted the CPO with concerns that the county department handling her grandchildren's child welfare case, was not providing her with financial reimbursements needed to help care for the children. The grandmother explained that when the child welfare case was opened and the children were placed with her, the county department agreed to help fund child care expenses. However, the grandmother stated that her efforts during the past several months to obtain the reimbursements were unsuccessful. The CPO contacted the county department to learn about the agreement and the steps they'd taken to provide financial assistance. The county department was initially unable to confirm that they had agreed to provide such reimbursements. However, after several requests from the CPO, the agency agreed to meet with the employee who originally worked with the grandmother. That employee confirmed that an agreement was made with the grandmother to provide her with reimbursement for child care costs. The CPO continued to monitor the case and was able to confirm the assistance was provided. In total, the county department provided the grandmother with approximately $5,300, which allowed the grandmother to catch up on past-due bills and ensure that the children had their needs met. The grandmother shared with the CPO, "I know this would never have happened if it not for your intervention. I am truly grateful for all of your assistance."

"...I am truly grateful for all of your assistance."

FISCAL YEAR HIGHLIGHTS

Launch of Timothy Montoya Task Force

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 with House Bill 22-1375. In September 2022, the Policy Collaborative for Children & Families launched the task force to study why youth run from care and develop a consistent, prompt and effective response. Meeting seven times during FY 2022-23, the diverse 22-member group discussed the lived experiences of youth and professionals, system responses, runaway behaviors and predictors. Members have also worked to address the insufficiency of quantitative data statewide, agency and facility protocols, practices in other states and the potential for a statewide response guide. The task force also commissioned focus groups through the University of Denver's Colorado Evaluation and Action Lab to provide first-hand perspectives from providers and youth in facilities. The task force's first-year report will be published and submitted to the Governor and General Assembly on October 1, 2023.

Launch of Mandatory Reporting Task Force

With the passage of House Bill 22-1240 during the 2022 legislative session, the Colorado General Assembly formed the Mandatory Reporting Task Force. The task force is charged with addressing 19 directives to consider the efficacy and equity of the state's mandatory child abuse reporting law and its impact on children, families and professionals across the state. The 34-member task force was launched by the Policy Collaborative for Children & Families in December 2022 and met four times during FY 2022-23. Topics discussed thus far by the group include concerns around mandatory reporting, the law's effectiveness, intentions of reporters, family services, the impact of race and ethnicity, lived experiences of youth and families, and data collected during reporting. The task force's first-year report will be published and submitted to the Governor and General Assembly on January 1, 2024.

Addressing Practice Concerns

Recognizing patterns in the experiences and concerns of individuals contacting our agency, we brought multiple practice concerns to the attention of state child protection agencies. For example, in June 2023, we delivered a letter to the Colorado Department of Early Childhood (CDEC) after the CPO was contacted by a client with concerns that the agency did not comply with state laws requiring public notice of unlicensed child care facilities providing improper child care. The CPO alerted CDEC of its concerns after the CPO's review found that the agency may not have provided all required information on the Colorado Shines website. The CDEC responded immediately and addressed the CPO's concerns. Another letter was sent in June 2023 to the Colorado Department of Human Services (CDHS) that detailed concerns with the practices and potential systemic bias by the Washington County Department of Human Services (WCDHS) in handling child welfare cases. Multiple cases opened by the CPO concerned clients who allege their cases were negatively impacted by the actions of WCDHS. These concerns include allegations that the former director made derogatory statements about clients. The CPO has requested that CDHS conduct an audit of the cases under the supervision of the WCDHS' former director and a review of notifications provided, if any, to families impacted by the actions of WCDHS. The CPO is continuing to monitor this case and the CDHS' response.

Identifying Systemic Issues

Appearing before members of the Colorado General Assembly in June 2023, our agency brought four systemic issues facing youth and families to the attention of the Child Welfare System Interim Study Committee. The CPO outlined four primary areas of concern: (1) Insufficient monthly contacts from county agencies with the parents involved in their child welfare cases; (2) The absence of statewide ethical standards for caseworkers and any law or regulation to take adverse action against an individual who acts unethically or unlawfully; (3) The current safety tool used to assess the immediate safety of children produces inconsistent results; and (4) Colorado's lack of law or regulation to ensure consistent and transparent standards regarding the quality of care provided to children and youth residing in residential treatment facilities. A series of recommendations for each issue was also provided as potential paths forward for the committee to consider.

Connecting with the Community

Our agency's expanded outreach capacity, resources and strategy have opened up new opportunities for engaging youth, families, populations overrepresented in child protection systems, rural communities, professionals and stakeholders across Colorado and beyond.

Youth Outreach

Utilizing the youth focus groups and surveys facilitated by the CPO during FY 2021-22, our agency took unprecedented steps towards making youth with experience in Colorado's child protection systems a central component of our work. We designed new outreach campaigns based on the feedback the survey provided on existing agency materials. These concepts were then used in our first digital marketing campaign with youth-related promotions reaching Colorado individuals Googling words and phrases similar to what a youth seeking our services would search for.

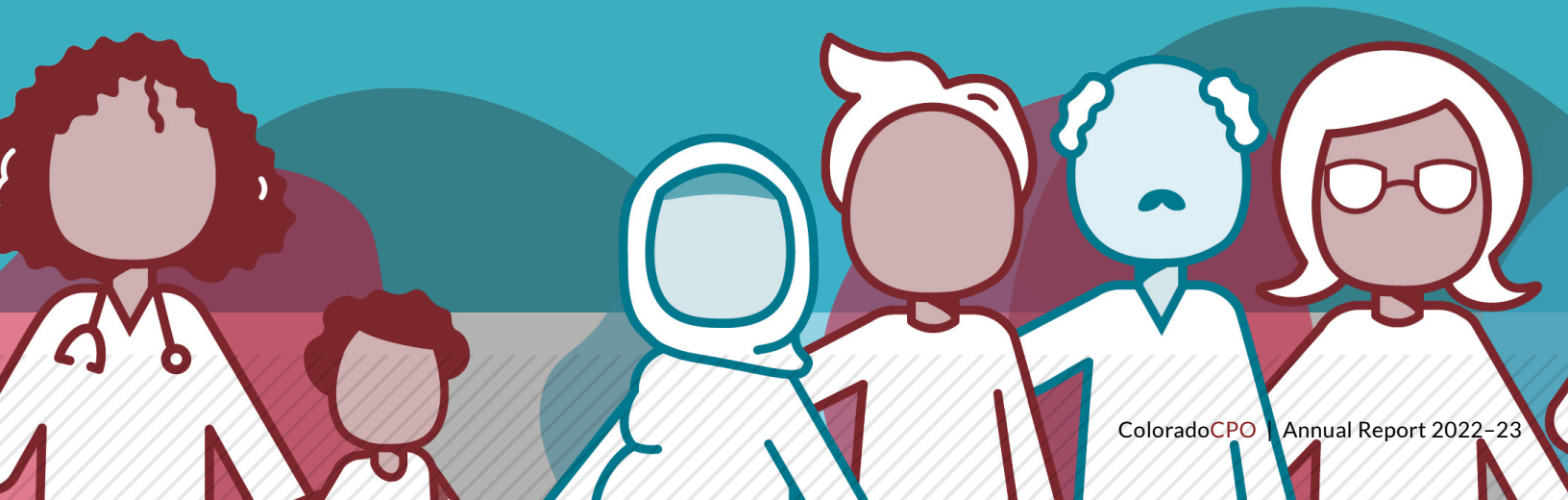
After securing funding for FY 2022-23, we began laying the foundation for the Tori Shuler Youth Voice Program (YVPwhich will directly engage Colorado youth through focus groups, policy initiatives and special projects. Involving youth voice from the start of a policy initiative is a key priority for the CPO. To continue developing the YVP, we met with Tori Shuler at Fostering Great Ideas, youth on the Lived Experts Action Panel (LEAPoperated by the Office of the Colorado Child's Representative and AmeriCorps' VISTA program. We will continue to develop this program throughout FY 2023-24.

Targeting Communications and Increasing Accessibility

The CPO serves diverse clients with unique concerns and circumstances. In recognizing this diversity, and after auditing the agency's communication practices and materials, our agency developed a new outreach strategy to connect with youth, caregivers, professionals and communities with messaging, mediums and information specific to these diverse groups. This included our 11-day digital marketing campaign that reached youth, caregivers and professionals in every region of the state. To increase inclusion in our outreach materials, we commissioned the design of new family icons reflecting youth and families of different races, ethnicities, genders, sexualities and cultures. We also began to improve the accessibility of both our print and digital marketing assets by reducing the complexity of text to recommended grade levels and developing a new website that is compliant with current accessibility standards such as color contrast.

National Presence

The CPO is widely recognized by ombudsman offices and child protection stakeholders across the United States as an innovative leader in this work. During FY 2022-23, we were invited to participate in critical conversations —nationally and globally—as well as provide consultation to other states seeking to use our agency as a model. Ombudsman Stephanie Villafuerte conducted presentations at the Kempe Center's International Virtual Conference, Global Oneness Summit and the United States Ombudsman Association Conference. Deputy Ombudsman Jordan Steffen also presented to the West Virginia Foster Care Ombudsman Office, New Mexico General Assembly and other states working to establish children and family ombuds offices. Additionally, Director of Client Services Amanda Pennington provided insight on our agency's work at the American Bar Association / Kids in Need of Defense Unaccompanied Immigrant Children's Service Provider Training.



ADVISORY BOARD

The CPO Advisory Board is an independent, nonpartisan board 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 set 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
Ann Roan, *Board Chair*
Benjamin Rounsborg
Hon. Amanda Hopkins
Hon. Kenneth Plotz

Governor Appointments
Judith Martinez, *Vice Chair*
April Lane
Aaron Miltenberger
Jerene Petersen

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

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 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

CPO STAFF

Stephanie Villafuerte, *Child Protection Ombudsman*
Jordan Steffen, *Deputy Ombudsman*
Karen Nielsen, *Director of Administrative Services*
Amanda Pennington, *Director of Client Services*
Michael W. Teague, *Director of Public Affairs*
Claire Hooker, *Senior Client Services Analyst*
Brittany Cornelius, *Client Services Analyst*
Abbey Koch, *Client Services Analyst*
Tiffany Lewis, *Client Services Analyst*
Wendy Oldenbrook, *Client Services Analyst*
Meredith Sullivan, *Client Services Analyst*

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CHILD PROTECTION OMBUDSMAN

FISCAL YEAR 2023-2024 PERFORMANCE PLAN

July 1, 2023

Stephanie Villafuerte
Child Protection Ombudsman

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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 the 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 2022-2023 Quarters 3 Performance Evaluation

During Quarter 3 (Q3) of Fiscal Year (FY) 2022-23, 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 full length Q2 Performance Evaluation, 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 2023-2024

- In partnership with former Colorado youth who experienced child protection systems, develop a multi-year youth outreach campaign that raises awareness of the CPO and its services for youth.
- Utilizing youth focus groups and research from previous fiscal years, design new digital and print promotional 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 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development of a CPO Youth Outreach Campaign strategic plan, including a fiscal analysis of projected costs for implementation and maintenance.
- 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 caregivers – including parents, relatives, foster parents and kin – of children involved in the child protection system to increase equitable access to services for all types of caregivers in every Colorado community.

Key Activities

FY 2023-2024

- In collaboration with caregivers with lived experience with child protection systems and various caregiver-serving agencies, develop targeted, multi-year outreach campaigns that raise awareness of the CPO and its services specific to different types of caregivers.
- Design new digital and print outreach materials that directly target different types of caregivers of children involved in Colorado's child protection systems.
- Promote the agency's services for caregivers through digital content and distributing printed materials to agencies, providers and communities serving caregivers.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development of a CPO Caregiver Outreach Campaign strategic plan, including a fiscal analysis of projected costs for implementation and maintenance.
- Distribution of new caregiver 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 parents, relatives or other caregivers, as measured by an increase in cases initiated by parents, relatives or other caregivers.

Critical Process: Promote awareness of the CPO among communities of color to increase equitable access to services for youth and families disproportionately involved in Colorado's child protection systems.

Key Activities

FY 2023-2024

- Collect and analyze client racial/ethnic demographic data to determine which communities the CPO is serving.

- In collaboration with a contracted equity, diversity and inclusion (EDI) specialist, develop targeted, multi-year outreach campaigns that raise awareness of the CPO and its services among communities disproportionately impacted by Colorado child protection systems.
- Promote the agency's services by engaging with and distributing printed materials to agencies, providers and stakeholders serving communities of color.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development of a CPO Outreach Campaign strategic plan that directly targets communities disproportionately impacted by Colorado child protection systems, including a fiscal analysis of projected costs for implementation and maintenance.
- Distribution of CPO promotional materials, in both English and Spanish, as measured by the number of sites in which printed materials are distributed.
- Publicly available race and ethnicity data comparing CPO clients to the Colorado overall population, youth population and demographics of youth and families involved in child protection systems.
- Increased services to communities of color that are disproportionately involved in child protection systems, as measured by an increase in cases from people identifying as belonging to those communities.

Critical Process: Promote awareness of the CPO among rural communities to increase equitable access to services for every community, county and region in Colorado.

Key Activities

FY 2023-2024

- Collect and analyze client location data to determine which communities the CPO is serving and what specific issues people are experiencing.
- In collaboration with rural stakeholders, develop a multi-year strategy to raise awareness of the CPO and its services in specific communities, counties and regions of the state.
- Design new digital and print outreach materials that directly target non-metro communities and regions around the state.
- Promote the CPO's services for rural communities through direct engagement, digital content and distributing printed materials to non-metro agencies, providers and communities.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Publicly available regional data comparing CPO clients to a multi-county region's overall population, youth population and number of youth and families involved in child protection systems.
- Development of a multi-year rural outreach strategy, including a fiscal analysis of projected costs for implementation and maintenance.
- Outreach with agencies, providers and stakeholders in counties with a population under 70,000 residents, as measured by the number of engagements completed per quarter.
- Outreach with agencies, providers and stakeholders in every region of the state, as measured by the number of engagements completed in each region.
- Distribution of new rural promotional materials, in both English and Spanish, as measured by digital impressions and the number of sites in which printed materials are distributed.
- The provision of services to those in rural communities, as measured by the number of cases initiated in rural counties.

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 2023-2024

- In collaboration with agencies and professional groups, design new digital and print promotional materials that directly target different types of child protection professionals.
- 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 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- 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]

Critical Process: Provide CPO staff ongoing training and education.

Key Activities

FY 2023-2024

- 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 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- 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

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

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 2023-2024

- Contract with an equity, diversity and inclusion (EDI) specialist to evaluate the CPO's internal culture, processes and business landscape.
- Provide CPO staff with ongoing EDI educational opportunities.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Development of an EDI Strategic Implementation Plan.
- The total number of EDI educational opportunities attended, as measured by the CPO's community outreach spreadsheet.

Strategy: Continue to develop the CPO's process and procedures for reviewing egregious abuse or neglect, near fatalities or fatalities of a child, as established by C.R.S. § 19-3.3- 103(1)(a)(I)(A).

Critical Process: Develop and implement a unique, research-informed process for reviewing critical incidents in Colorado to improve and advance child protection systems.

Key Activities

FY 2023-2024

- Facilitate an objective, multidisciplinary review of qualifying critical incidents to identify areas of the child protection system that can improve.
- Draft and distribute public facing report describing findings from reviews.
- Assess possible improvements to the CPO's process for reviewing critical incidents in Colorado.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

[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.

Key Outcome(s) and Metrics

- Increased knowledge of how the state's child protection system is currently working on a systemic-level and the identification of recommendations to improve the system, as measured by the number of qualifying cases received by the agency.

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 2023-2024

- Produce quarterly 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 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- 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 2023-2024

- Facilitate the Mandatory Reporting Task Force, as established by C.R.S. § 19-3-304.2.
- 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.
- Launch the Tori Shuler Youth Voice Program and engage current and former youth with lived experience in Colorado child protection systems through focus groups, initiatives and special projects.
- 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 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- Key activities are completed yearly.

Key Outcome(s) and Metrics

- Publication of the statutorily required Mandatory Reporting Task Force Interim Report.
- Publication of the statutorily required Timothy Montoya Task Force Interim 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 stakeholding, 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 on child protection issues.

Key Activities

FY 2023-2024

- 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.
- Serve as an independent, neutral and objective resource for the Child Welfare System Interim Study Committee.

FY 2024-2025

- Key activities are completed yearly.

FY 2025-2026

- 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.

Introduction

Every year, the Office of Colorado's Child Protection Ombudsman (CPO) reviews more than 1,000 cases, each of which are brought to the agency by citizens with a concern, frustration or question regarding the state's child welfare system. By design, the CPO is charged with independently assessing these concerns and helping citizens gain clarity regarding these systems.[1] Unlike any other agency in Colorado, the CPO is uniquely positioned in state government to impartially study the child welfare system, through the perspective of the people it impacts.

Since its inception as an independent agency, the CPO has received thousands of cases from parents, youth, siblings, extended family and professionals connected to child welfare systems. Those cases have revealed systemic issues impacting the safety and well-being of children and families in Colorado. They have also highlighted a pervasive erosion of the public trust in child welfare systems in the state.

While the CPO is charged with looking at all entities that serve children and families in Colorado, this committee has specifically requested information regarding issues with how child welfare services are administered in the state.[2] During the past seven years, the CPO has identified, studied and reported on many of these issues. As such, the CPO is providing four issues currently impacting the child welfare system in Colorado. The CPO has provided a summary of each issue and possible legislative solutions for the committee's consideration.

ISSUE #1: Colorado must find more effective and creative methods to support county departments to ensure that parents involved in child welfare cases receive required monthly face-to-face contacts with caseworkers.

Every month, less than half of all parents involved in child welfare cases in Colorado receive the required monthly face-to-face contacts with child welfare services. Since its inception, one of the most consistent concerns the CPO hears from parents with open cases – including parents whose children have been removed from their care – is that they are not receiving regular contact with child welfare services. Current state data shows that difficulty maintaining such contact is a pervasive issue.

Why It's Important

Inconsistent or insufficient communications with parents or other caregivers can delay the administration of services for children and families, delay needed safety assessments for children and, in some cases, delay the proper return of a child to their parent's care.

After a child welfare case is opened, state regulations require child welfare services to make and document monthly efforts to meet with all parents face-to-face.[3] Current data from the Colorado

[1] See C.R.S. §19-3.3-101 to 111
[2] See C.R.S. §10-3.3-102(1)(a)(III). The CPO does not have authority to review the actions of attorneys or judges. In pertinent part, the CPO's enabling statute states the CPO shall "refer any complaints relating to the judicial department and judicial proceedings, including but not limited to complaints concerning the conduct of judicial officers or attorneys of record, judicial determination, and court processes and procedures to the appropriate entity or agency within the judicial department."
[3] See 12 CCR 2509-3, 7.204 – Case Contact Requirements

Department of Human Services (CDHS) shows that compliance with this rule has not exceeded 47% during the past five years.[4] This means that that during the past five years, less than half of Colorado parents involved in child welfare cases have been contacted face-to-face the required amount.[5] A closer review of that data shows that, during the past year, some child welfare departments have dropped as low as 10% compliance with this rule. Some child welfare departments are as high as 84%. The standard set by the U.S. Department of Health & Human Services' Administration for Children and Families is that 41% of all parents involved in child welfare cases will receive a monthly face-to-face contact effort by county departments.[6]

The CPO is acutely aware that the child welfare system – both in Colorado and nationally – is struggling to retain and recruit a qualified workforce. Such difficulties inevitably have significant impacts on the delivery of services to children and families. In reviewing these cases, the CPO has found that many county child welfare departments share the CPO's concern that contacts are not occurring as frequently as needed or required. They have routinely cited a consistent lack of support and resources as one reason this issue persists.

Without regular contact with child welfare services, parents are not able discuss key elements of ongoing cases, such as parenting time decisions and issues related to treatment plans. Conversely, without making monthly contact with parents, there is no ability to observe the home to determine whether it is safe for children. The cumulative effects of these missed contacts, in many cases, impedes a parent's ability to comply with case requirements. It also delays the return of children to their parents and homes. But failing to attempt to make monthly face-to-face contacts with families also poses a significant risk to the physical safety and well-being of children who remain in their homes.

For example, the CPO received a call from a relative of a sibling group who remained in the care of their mother during an open child welfare case. The children's relatives worried for the safety of the children, stating that the children's mother was suffering with mental health issues, using illegal substances and that the children were being physically abused by the mother's boyfriend. The CPO's review of the case found that the mother was not contacted face-to-face for 13 of 22 months – almost half of the time the case was opened.

It should be noted that, in many cases reviewed by the CPO, court filings do not reflect this deficit. As a result, judges are making decisions regarding the placement of children and treatment plans for caregivers, without knowledge that required contacts were not made.

Potential Solutions

1. Develop legislation to convene a public-facing working group within the Colorado Supreme Court Improvement Program. This group should assess current compliance rates with monthly face-to-face requirements and the impacts on child welfare cases, judicial decision making and children and families. This group should also consider alternative methods and models to increase face-to-face contact with parents.

[4] This figure is based on available C-Stat data provided by the CDHS' Results Oriented Management System. C-Stat measures key areas of county child welfare department performance, including monthly contacts with parents. The figure above is an average of all county human services departments monthly face-to-face contacts with parents. It should be noted that some county departments exceed 47% compliance each month and others were dramatically below this rate.

[5] This data takes into consideration parents who do not reside in Colorado, are incarcerated for longer than two years, and those whose whereabouts are unknown.

[6] See U.S. Department of Health and Human Services Administration for Children & Families' Colorado Child and Family Services Reviews Final Report 2017

ISSUE #2: Colorado needs to support strong and effective caseworkers by creating standards that ensure caseworkers who act unethically or unlawfully are not able to continue providing child welfare services to children and families.

Colorado currently has no law or regulation regarding adverse action against child welfare employee's certification and no requirements that clients or departments are notified of verified, gross misconduct. Seven years ago, the CPO first raised its concerns about the lack of clarity – and correlating law and regulation – regarding the certification of child welfare employees in Colorado. The current system lacks clarity regarding whether CDHS or county departments are responsible for seeking revocation of child welfare certifications. Colorado currently lacks any process to take adverse action against an employee's certification in instances in which the employee violates state law, regulation or other areas of ethical concern. The impact of this gap is that, unless an employee is criminally charged, there is no way to know whether a child welfare employee has violated regulations or ethical standards. As such, their certification to work with children remains in place and they are able to move from county to county undetected.

Why It's Important

Without a mechanism to take adverse action against a child welfare employee's certification, there is no effective way to ensure Colorado children and families are served by qualified individuals who maintain industry standards.

Since 2015, the CPO has identified four incidents in which child welfare workers have been criminally charged with falsifying records in the state child welfare database.[7] The majority of these false records indicated the employee had seen a child and/or assessed their safety when they had not. In at least one of the cases above, the employee was rehired by another county department prior to criminal action being taken. To be clear, these cases represent a small minority of child welfare employees in Colorado. And yet, the impacts of these cases permeate through the entire system and erode the public's trust in the very individuals charged with keeping them safe.

In Colorado, there is no mechanism in the state to take adverse action against a child welfare employee's certification after it is received through the Colorado Child Welfare Training Academy. This deficit makes it nearly impossible for county departments hiring child welfare employees to determine whether an employee has a history of misconduct or concerning practice.

County human services departments may take direct personnel action when an employee violates county and state regulations or commits a criminal act. But they have no mechanism to take adverse action against the certification of a child welfare employee. There is also no standard statewide policy for investigating such incidents. As such, instances of misconduct are handled dozens of different ways. Equally important, the children and families involved in these cases are not aware of the misconduct and potential impacts to their cases and other county departments are unaware of incidents when hiring employees.

Employers should be provided with more information regarding the individuals trusted to assess the safety and well-being of Colorado children. Additionally, children and families should have meaningful

[7] See "Denver caseworker charged with falsifying records in fatality case" published in The Denver Post on January 22, 2015; "Jefferson County caseworker admits falsifying child abuse records" published in The Denver Post on January 9, 2018; "Moffat County caseworker accused of fabricating child abuse, neglect investigations has been charged with forgery" published in The Colorado Sun on March 30, 2022; and "Former Arapahoe County social worker failed to properly investigate child abuse cases, state audit finds" published on 9New's website on September 26, 2022.

access to information about the standard required of each child welfare employee working with them and proper notification when verified misconduct may have impacted their case. By allowing child welfare employees to maintain a certification regardless of performance, ethical violation or possible criminal activity Colorado is putting children and families at risk.

Potential Solutions

1. Develop laws and applicable regulations regarding the following:
    a. Processes for seeking adverse action against child welfare certifications;
    b. Standard and required notification practices for clients and county departments for when a certification is revoked for cause;
    c. Required development of a statewide, standard policy for investigating cases of alleged misconduct;
    d. Required development of a statewide, standard code of ethics for child welfare employees; and
    e. Development of a public-facing database showing the certification status for all child welfare employees administering services.

ISSUE #3: The current safety tool used by child welfare services to assess the immediate safety of children has never been validated and does not produce consistent results.

The Colorado Family Safety Assessment Tool is the accepted safety tool for child welfare services in Colorado. However, since its inception in 1999, the tool has never been validated. Reviews by national and state professionals have found that the safety tool continues to be utilized inconsistently by child welfare services. The safety tool is a crucial step in assessing the initial needs of a family, the immediate safety of children and, in most cases, whether a child will be removed from their home.

Why It's Important

Unable to yield consistent results, Colorado's unvalidated safety tool creates the potential for bias that may impact decisions made in child welfare cases.

The safety tool includes details of current danger and harm to children, parent functioning and strengths, child vulnerabilities and efforts that have or can be made to mitigate safety concerns. When there is current and impending danger to a child, child welfare services must make the decision to either create a safety plan with the family or remove the child from the caregivers and obtain custody of the child. The safety tool is intended to provide an objective and consistent tool to ensure that decisions affecting child safety are made appropriately. Despite its intended use, the safety tool is used subjectively and inconsistently.

Concerns regarding the use of the safety tool have long been raised by the CPO, as well as others monitoring its use. The first review of the tool took place 15 years after its inception.[8] That review included a study by Colorado State University's Social Research Center (CSU).[9] In that report, CSU was able to validate the state's Colorado Family ***Risk*** Assessment Tool – which is distinct from the safety tool. CSU found that the risk tool could be used consistently by child welfare services. However, CSU could not do the same for the ***safety*** tool. The CPO is unaware of any additional efforts to validate the use of this tool. During 2016 to 2018, CDHS worked to update regulations surrounding the use of the

[8] See Colorado Office of Children Youth & Families Division of Child Welfare Services: 2020 Colorado Program Improvement Plan, In Response to the 2017 Child and Family Services Review, Official Submission May 27, 2019
[9] See Colorado State University College of Health and Human Sciences' School of Social Work: Colorado Family Safety and Risk Assessments: Validation and Revisions, Final Submission January 16, 2014

safety tool and provide additional training to all child welfare employees.[10] However, concerns with the use of the safety tool were again noted by the U.S. Department of Health and Human Services in 2017. In the federal performance improvement plan for Colorado child welfare services, the state's application of the safety assessment included it as an 'area needing improvement' in the state's performance improvement plan.

To date, there has been no additional formal review by the state to ensure that the tool is being consistently utilized as designed.

The CPO routinely reviews cases in which the use of the safety tool is at issue. These cases have revealed systemic impacts, including:

- Safety planning and monitoring were insufficient to manage child safety;
- Safety plans were not created, completed appropriately or communicated to families;
- Safety services that were needed were not provided; and
- Safety plans created were not with the ability of the family to complete.

CPO case reviews have identified that there is a lack of understanding in how to apply basic principles of safety planning and how to create safety plans that were appropriate and met the needs of the family.

The impact is that a child may be removed from their caregivers without cause. Conversely, a child may not be removed from a home when valid safety concerns exist.

Potential Solutions

1. Commission a third-party audit of the state's safety tool to include an analysis of the use, efficacy and reliability of the current tool, as well as possible alternative models. The final report shall be provided to the Colorado General Assembly and child welfare stakeholders.

ISSUE #4: Colorado currently has no laws or regulations ensuring consistent and transparent standards regarding the quality of care provided to children and youth residing in residential treatment facilities.

Following the high-profile closure of the El Pueblo Boys & Girls Ranch in 2017, the CPO identified the need for increased and consistent monitoring of residential treatment programs at the state-level. This included recommendations to develop standardized procedures for monitoring licensed facilities and creating more transparency regarding the conditions, services and outcomes in residential treatment programs. However, none of these recommendations have been implemented.

Why It's Important

Families rely on residential treatment programs, however, the state's monitoring system for these facilities is leaving some youth in potentially unsafe conditions.

Colorado's state-licensed residential treatment facilities offer critically important services to some of the state's most high-needs children, including those with severe behavioral health and psychiatric needs. However, Colorado currently lacks a system of quality assurance standards and a collaborative model of quality improvement in which providers and oversight agencies may ensure that such

[10] See Colorado Office of Children Youth & Families Division of Child Welfare Services: 2020 Colorado Program Improvement Plan, In Response to the 2017 Child and Family Services Review, Official Submission May 27, 2019

facilities meet consistent standards. Currently, there is no standard quality assurance system in place for residential child care facilities licensed by CDHS. Additionally, there is no public-facing system that provides caregivers with information about the facilities children and youth are being placed in.

During the past several years, several state-licensed placements have been the focus of the CPO and local media.[11] During 2017, the El Pueblo Boys & Girls Ranch, a center for youth with severe behavioral and psychiatric needs closed. The year preceding its closure, the facility was the subject of dozens of complaints regarding the safety and well-being of the children and youth who were residing there. The CPO reviewed the circumstances surrounding the facilities closure for more than a year, including the complex systems and multiple actors tasked with ensuring the children and youth were receiving quality treatment and care. The CPO published its report and summary of its findings and recommendations for improvement in 2019.[12] Since the publication of its report, the CPO has continuously monitored residential child care facilities, studied the laws and regulations that guide them and engaged families that have been impacted by them. However, many of the recommendations contained in that report have not been implemented, including a recommendation to develop systems that improve the transparency surrounding the conditions and services provided in residential child care facilities.

In 2020, the CPO was notified about the death of 12-year-old Timothy Montoya, which ultimately served as yet another example of why Colorado needs quality assurance and accountability systems for state-licensed facilities. In response to Timothy's death, House Bill 22-1375 established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement, which is tasked with addressing and reducing the number of children and youth who run away from care.[13] However, the portion of HB 22-1375 that would have solidified the first steps in implementing a quality assurance and accountability system for state-licensed facilities was severed from the bill.[14] As such, the CPO believes that legislation – specifically the provisions originally drafted in HB 22-1375 – are needed to ensure that a system is not only developed, but that is it developed by a broad range of individuals with personal and professional expertise.

Potential Solutions

1. Introduce legislation to develop quality assurance and accountability systems for state-licensed facilities, including a public-facing database that allows parents, caregivers and county departments to access information about the ongoing performance of such facilities.

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[11] See "Families kept in the dark about children's safety in Colorado's child welfare system" published in The Colorado Sun on May 19, 2021; "With bites, bruises and low pay, caretakers for Colorado's troubled youth say there's not enough staff to keep kids – and each other – safe" published in The Colorado Sun on May 18, 2021; and "Advocates to push for overhaul of Colorado's youth residential centers – and they're looking to Florida for help" published in The Colorado Sun on December 29, 2021

[12] See Office of Colorado's Child Protection Ombudsman: Investigation Report, Case ID 2017-2736, published August 12, 2019

[13] See Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement

[14] See introduced version of House Bill 12-1375

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

REPORT HIGHLIGHTS:

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

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Abstract

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

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Acknowledgements

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

Data Sources

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

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Note on Language Regarding "Runaway"

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

Introduction

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

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

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

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

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

Project Rationale and Description

Project Rationale

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

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

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

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

Project Description

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

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

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

Methods

Purpose of Qualitative Research Perspectives

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

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

Sample

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

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

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

Focus Group Protocol

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

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

Key Findings

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

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

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

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

Focus group participants indicated three conditions that led youth to run from their out-of-home placement.

- **Running from the placement due to dysregulation from triggering events, disconnection from staff, and responses to previous trauma.**
- **Running to connectedness and familiarity.**
- **Running due to typical adolescent behavior.**

Conditions that Led to a Run: Running *From*

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

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

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

Triggering Events

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

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

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

A Disconnection with Staff

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

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

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

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

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

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

Responses to Previous Trauma

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions that Led to a Run: Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Opportunities for Prevention: Consequences and Connectedness

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

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

Fear of Consequences

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

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

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

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

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

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

"We'll have a kid that has had a really bad family therapy session or a bad phone call or something and gets really upset. And so, that fight or flight kicks in and their go to is to flee in many situations, but our staff really work hard to try and intervene and just, you know, get their brain and their body back to a place where the adrenaline and the cortisol isn't just pulsing through them. Often times when the staff are able to get their body just regulated, those compulsive urges to just take are just kind of gone. Then we can further process. But I've seen many, many situations where as soon as we get the kids body back to a state of regulation that impulsive urge really just – it's dissipated."

"I actually just had this happen with a kiddo this past weekend where he wanted to leave after a bad phone call with dad and leaned on myself because I was his therapist to really try and encourage him – or pull him out of that headspace of wanting to run. And a lot of times it's a battle within themselves on what they're going to do. I've seen it a lot where they try and lean on kind of us as their safe space to support them."

Connectedness with Provider Staff

As demonstrated above when a provider successfully talked a youth out of a run, connectedness with a provider emerged as a strong running prevention strategy. Youth described staying where they feel safe, seen, heard, and valued. Youth indicated that taking a short walk with a staff member is all they needed to calm down, process, and return to their program. However, as discussed previously, staff shortages significantly limit providers' ability to establish and maintain the kinds of connections with youth that allow staff to anticipate when youth are heading toward dysregulation and a potential run.

"I just want to point out like this lovely staff on the left here. I look forward to her smile every single morning. Like even if she's [the staff] going through something, she will always come into work with a smile. I hardly ever hear, "I'm proud of you from any of my family members." But you go to her and she's like, "Great job. Like I'm proud of you." She will not point out your flaws, but she will always compliment you on things that you're doing successfully. If I'm ever sad, I just want to see her smile. And it's just so goofy, and silly, and I love it."

"It's connection with people, when kids have good connection and you're able to pull that person into maybe the situation that's brewing, that may help make that child be able to process differently. It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day."

"We're always using and putting ourselves in positions to try and intervene in a non-physical way first at the lowest level, making sure that we do have incentives in place and goals, and distractions and everything possible to prevent them, engaging them with activities. I know we now have our rec team and our rec therapists. We have the kids riding bikes around the track and getting outside, and doing things to try and prevent them from even wanting to run, but I'm going to be honest in the

> fact that it's dangerous for a lot of these kids that we're working with to get out of the facility and out of staff supervision because they're on a one-to-one supervision throughout their time."

Connectedness with Peers

Peer connectedness was also reported as a means of prevention. Youth described leaning on trusted peers to talk them through issues like anger, frustration, and disappointment and felt calmer as a result. Youth also described talking to each other and rationalizing about potential consequences for running.

> "I guess me personally, I've helped out a couple friends that were in that head space of running away. But all I normally do is just sit there and talk to them and see what's going on, and then, if something's wrong and they're really just sitting there and just – I guess the best way to describe it is just sitting there and reflecting on it and just letting it bring them down in that head space. I just try to talk them out of it."

> "I've talked to people—it would be beneficial to learn how to understand the fact that whether or not it's happening instantly, something good is going to happen, whether that be something simple, like not having the opportunity to go on passes and then having the opportunity to go on passes, or discharging and having—still having restrictions at your house, and then being able to do more stuff as time goes on because you worked for it and you've earned it. So, it doesn't matter if it's instant or not; it's something that's going to happen"

Conclusion

Connectedness matters for children and youth in out-of-home placement. Connection between caregivers and youth is essential for the mental well-being for all youth, but especially for youth who have experienced trauma. Youth run as a means of getting their needs met, and at times this can result in tragedy. Young people do not always have the developmental capacity to fully anticipate or comprehend the consequences of their actions. However, connectedness is a protective factor that can serve as run prevention, intervention, and aftercare. Unfortunately, when connection is made more difficult by a workforce shortage, that puts kids at higher risk of becoming dysregulated and running.

In order to enable connectedness, treatment facilities need to be adequately staffed and have the time and support they need to make meaningful connections with youth. Providers also highlighted the need to clearly define terms in C.R.S. § 26-20-102(6) considering the variety of circumstances under which running incidents occur. Providers indicated the need to work with state agencies and law enforcement to define the word "imminent" and come up with solutions to help providers to have more autonomy in running prevention efforts.

Appendix A: Semi-Structured Interview Protocols for Youth and Providers

Youth Questions

As we talked about in the consent form, I am here today to listen to your thoughts about why young people run from out-of-home placements (like treatment facilities or foster homes). The people listening to what you have to say today want to understand more about why people run so they can make things better for you and other people who live in an out-of-home placement. I will ask you some questions about experiences you, or someone you know, has had with running. There are no right or wrong answers and you can share anything that feels important to you.

1. Why do you think young people run from out-of-home placements?
2. What was happening for you, or someone you know, right before running?
3. Do you know of someone who has thought about running but decided not to run? Tell us more about what you think it was like for them.
4. Have you ever felt like you wanted to run from an out-of-home placement? If so, did you run? Why or why not?
5. Has anyone who has stopped you, or someone you know, from running? What was that experience like?
6. How would you feel about yourself or a friend being restrained by a staff member to stop you from leaving an out-of-home placement?
7. Was there something a staff member did that made you want to run away? Was there something a staff member did that made you want to stay/not run away?
8. What do you think would stop someone who was thinking about running from running? from thinking about running?
9. Where are some of the places young people go when they run? Why do you think they go there?
10. What happens to people after they come back to the out-of-home placement after running? How are they treated? Is there anyone who helps them?
11. Is there anything I did not ask that you think I should know about people who run from out-of-home placements?

Provider Questions

The following questions were asked of provider focus group members after the informed consent and demographic questionnaires were completed.

1. Why do you think young people run from out-of-home placements?
2. Tell me about some things that are happening for young people right before a running incident?
3. How often do children you work with talk about running from their out-of-home placement?
4. Can you think about a time where a young person thought about running but did not? What was that experience like, and what do you think prevented them from running?

5. What do you think about physically restraining a young person to prevent them from running?
6. What do you think would stop someone in your placement, or children in general, someone from thinking about running?
7. Where are some of the places young people go when they run? Why do you think they go there?
8. What happens to young people in your placement when they return after a running incident? How are they treated? What supports are provided to the young person and their family? What conversations do you have with the young person regarding why they ran? What plans are discussed with the young person regarding preventing future runs or ensuring safety of the young person while on the run.
9. What, if any, have your experiences been like with law enforcement when young people run from their out-of-home placement?
10. What do you think needs to happen to prevent someone from running from the out-of-home placement where you work?
11. Is there anything else I did not ask that you think is important to share?

Appendix B: Additional Focus Group Participant Quotes by Topic

Topic I: What conditions led to running from an out-of-home placement?

Conditions that Led to a Run: Running *From*

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

Triggering Events

"Often in our facility, it happens when a kid gets bad news, or gets told no to something that they're really wanting. We see kids run for numerous reasons, whether it be getting caught for doing something they weren't supposed to be doing, being held accountable, or even a phone call with a future placement that doesn't go well. Often, they're super dysregulated and not necessarily thinking about their future; it's in that moment, what's going on."

"The majority of any clients who have actually run, and it's because they've gotten bad news from their team or they've got extension or it's like it's now side factor, they got bad news and we had nothing to do with it."

"I definitely think that that's a pretty big factor. But I also think, since that is their team, sometimes their families call and tell them. We had a kiddo a few weeks ago that mom called and said a Dependency and Neglect case was open on her. And we didn't know that, and the kid was upset for a long time and finally it came out. Even just their families. But I do think the teams often tell them information that would be good for us to know in advance."

"It's kind of an uphill battle for us at times to get it in place. You try to keep those kids, you know, where they're at. But I think their trying to really be with family or be around friends, that kind of stuff, is a pretty common reason as well."

"I think there are times that we know in advance as well and are able to provide support, but I do think that it's not just their teams. It's also families. A lot of times they're with us because their families are unhealthy and have unhealthy patterns, and that comes out in phone calls, and they share stuff that they shouldn't share or we should know before they share, and that doesn't always happen unfortunately."

"We saw a lot of times just the uncertainty that kids have around what they're being told by their teams because they couldn't comprehend what treatment was and what that looked like for them as far as how they were going to complete something, as much as we would try to break it down and have them understand. Objectives from the different players on their teams, that uncertainty and disappointment."

"Some kids will have a bad phone call, so they're running from that even though that physically isn't here but it feels like it is."

Disconnection with Staff

"There is some staff that make it to where the youth that are causing the issue are their one priority. Like if there's a youth screaming, yelling, whatever, they said, 'Oh, wait, we're gonna have to wait to process because this is –.' It's just, it's frustrating because we don't have enough staff on the floor to process, or if we don't communicate how we feel, we get in trouble for it. It's, like, some of us don't even know how to communicate how we feel. It's hard to just tell staff how we feel, especially when it's like we don't feel that most staff listen."

"I just graduated high school here. I just, I'm trying to move forward, and I can't do that when everyone else on the unit needs something else. There's probably I think 13 or 14 people on our unit, and like day-to-day, staff when we have time for to get to three or four to be able to talk to them about what they're going through that day."

"I've never I've never AWOL-ed here. I've had the thoughts of going to AWOL, or walking out. I don't know. Maybe like the lack of consistency, or it feels like we're not being listened to sometimes."

"The de-escalation tactics are either, hey, let's sit down and talk about it. If you can't talk about being unsafe, we're just going to restrain you. It's like I either choose to be restrained, or I choose to run out of the gates because I'm so escalated, and nobody's gonna let me breathe. It feels very caged and trapped right before I have to feel like I need to walk. It's happens more often than not."

Responses to Previous Trauma

"You could have told by my face. You could have told by my body language, that I was not okay. And they just like ignored it, and pushed it off, like, oh, we're talking about the unit having bad hygiene, or bullying. It was one of those groups, and I just need to leave. I'm going to flip. And I have like talked prior to this to a staff, and said, I just need to go on a walk to get my adrenaline out. Because it's like, you know, when you have ADHD, and then you have like bad anger, like when you get to the point where, like you're mad."

"I feel like sometimes when people went AWOL, they, they feel like they can run from their fears and their problems, and I know for a fact, that's not true. You can't run from your problems. You can't run from your traumas, and from your fears. What happens before people go AWOL is that either they get so worked up, that they just can't handle it anymore, then they just walk out. It gets to the point where it builds up so much, that you can really walk out to help it feel better."

"Some youth self-harm because they just want to feel better. They want help. And so staff don't get that, they'll just like quickly give you an assignment or something like that. Yeah, they have a self-harm assignment, which I think is just – it doesn't help, whatsoever. The only kind of recognition I get is when I walk."

"A lot of times, these kids try to run away to harm themselves, as well. There are a lot of threats like, 'I'm going to run in front of traffic,' or 'I'm going to kill myself,' right before they run out the gate."

"Sometimes this place, or wherever they are, is the safest place that they have been. And I think that that scares a lot of our youth. And so, they want to run back to the place that they feel comfortable with and, like someone else mentioned, run back to their friends or and things like that. So, I think

feeling safe and secure in a place really scares them, and so, they want to go back to what they're feeling comfortable with."

"I think sometimes they're just self-sabotaging, too, like they know that they have a safe place in here and they're cared for, but then they get scared that they'll have to leave eventually so they want to sabotage themselves. They want to run away and act out to make sure they don't leave anytime soon."

"I feel like some could just be scared to come into a facility like this one. Not that there's necessarily anything to be scared of but some people might just be scared and want something different and run."

"It's just really across the board because sometimes kids can take off and they seem calm and regulated and seem like things are fine. Other times they'll take off as a result of some sort of trigger that occurred and they get really emotional and upset."

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

"There was a time where I was planning an AWOL, where I was going to find somebody's phone, to run back to a home that I was previously at. I was going to call. I was gonna, 'Hey, come pick me up. I want to come home.' It was never my plan to like go to Walmart or anything. I was just trying to find a cell phone so I can get a ride to my house. I wanted to go home. I wanted to see people that haven't seen in a while, and I'm just like, 'I miss you guys, pick me up.'"

"My sister, for instance, she's ran to, I guess, her friend's house just so it's away from family, and she can just sit there and think. Or she just goes somewhere where it's peace and quiet."

"Some kids can go on passes and just stay and not come back. It doesn't necessarily have to be like they go on the pass and then they run away. It can just be they go on the pass with their family and then they just stay with their family and don't come back."

"They [peers] sometimes just want to go home. I know a bus place not that far from here like in a town over there. One night me and [another youth] went AWOL. But then the cops came and I had to say I'd give up."

"We broke into a house. Oh, and when we have the opportunity to drink, and we have the opportunity to smoke, we're gonna do it. There was like a whole tray of alcohol sitting inside so I broke in and I stole the alcohol. I stole the iPad. I stole shoes. And we went out, and we got drunk. That's how I go when I go AWOL."

"I need to leave this place. I need to get back home."

"There's running from something and running to something…friends, drugs, the families, probably in that order…"

"I think it's discussed most within the population of like the trafficking youth. I think a big reason for that is, these traffickers know substances to keep those kids under control. Right? They know if the kid would go into placement or even run away from them that after a few days they start showing like withdrawal symptoms and they're going to run right back. I think the substance abuse stuff, it causes a lot of those conversations too. And those are the kids that we see having those conversations the most in our care, are the traffic youth."

"What they know is coping, right? They know to go and use substances, they know to go and find a place where they can do the things that make them feel good in the immediate."

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

"I notice that every time I've seen someone run from a home or a facility they've always went to a store for some reason. I don't know why. Maybe it's that feeling of being free and being around other people that have that same opportunity of just being free and doing their own thing."

"They [peers] usually go down the street to the skate park, somewhere to hang out with other people."

Youth Who do not Understand Consequences of Typical Adolescent Behavior or Intentional Running

"Some people end up getting chased by animals, apparently fighting bears. Laying on the side of a foothill for the night. Going to Walmart, and dyeing their hair in the Walmart bathroom. Sprinkle in some hanging out with some random homeless people under the bridge. Some people get robbed by hobos. And, you know, and get drunk, but they're still drunk two days later."

"I think a lot of people don't know where to go, but like some people go towards that cactus field out there. It was like my first place I went."

"When I went with [another youth] one time he asked people from vehicles from a skating rink like in the parking lot who came out of their vehicles, and he was sitting on the bench crying to make it look like he was injured or something. He kept on asking people for favors from like cash."

"I go most when I AWOL is – the first time, I was just out in the wilderness. The second time – well, the few first times, I was out in the wilderness. Second time, I hid in a porta-potty."

"Some people talk to random people and be like, 'I used to be like you.'"

Youth Rights and Justice

"I've AWOL-ed a lot of times while I've been here. Personally, the things that triggered me to AWOL, sometimes it's phone calls because you only get a certain amount of people o++n your call list. And the only one I can call is my mom. And it's hard sometimes because when they refuse you phone calls, it makes you – it just makes me feel like they don't care. So you feel like you need to walk out, or AWOL. But I AWOL because, usually, it's just me because I'm pissed."

"I'm pissed, and staff will process with me about it. I felt like, because when I first got here, the reason I AWOL-ed was because I wouldn't get my personals. I did not feel comfortable in the clothes that were provided here. They refused my clothes because they said that it was a privilege to have

my clothes because if my behavior isn't on point, I don't get my clothes. I was, I was just kind of angry about that."

"I guess being locked down, not being able to have freedom."

Topic II: What efforts were made to locate a child or youth after a running incident?

Contacting Law Enforcement after a Run

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

"Sometimes the police, they look at the kiddos file and their diagnosis and their history and make a really quick decision on whether the kid is high-risk or not and don't always take into account the fact that we worked hours and hours with these kids. We know these kids. We know their families. We know the background. It can be very difficult and challenging too, when you're sitting here telling a police officer like, 'This kid is high-risk. We need to – you know, you need to be looking for him, and they're like, 'Yeah, if he doesn't show up in a few hours we'll send someone out or we'll let everyone know to kind of keep an eye out.' But you know when they're telling you they're not actively looking for a kid."

Staff concern About Youth Who Run

"We saw a lot of walkaways, or running away when they would get dysregulated. We were out in the middle of nowhere, and so they would become dysregulated. Maybe they had a bad phone call, a bad visit from their family and/or client manager, caseworker, GALs [guardians ad litem], and we would just see them do that walkaway thing. Towards the end, we had a perimeter that we could follow them and try, you know, engage them to come back. With their dysregulation and their age, it did become a safety issue for them."

"I think for us, one of the things that we rely on is planned interventions. If we know that kids have a history of that unsafe behavior or running and they're looking for that freedom, we can place kids on AWOL precautions where we engage in extra supervision with these kids. We put them in clothing that is easily identifiable so if they run, we know exactly what they're wearing, so those planned interventions make a big thing. The second thing is programming, making sure that the kids are engaged in things throughout the day, and that less time for idle hands, the less time for them to really kind of make decisions for themselves, to make sure that they don't have the time to think about, 'Hey, I want to AWOL,' and then go."

Trafficking

"I used to do transportation, that I've had to go all the way to [another state] to pick up kids. I went to other states to pick up kids that went AWOL, and it's really scary to me to know, especially that that truck stop is going to be there, that there's going to be a hotel there; what are these kids going to be doing at some point in time? It is really terrifying to me."

"With our population right now, we have numerous youth that are on clinical precautions and have been for months, that if they get a hold of the wrong type of lid or the wrong piece of plastic off of a container, they've got lacerations and cuts all over their bodies. We're working with kids right now that are so out to self-harm that to allow those kids into society without having someone to intervene is scary. For us, it does determine that that is an imminent danger for themselves. Then, we also are working with a youth that we're learning over time is in imminent danger because if she gets out of the facility, she runs to a house and goes in a house—she is developmentally delayed—and then she is assaulting people with anything she finds on the road or going in front of traffic just because."

"They go to [a store] down here. They ask for rides, they ask people to buy them whatever they need. They just steal it, they'll shoplift, they'll just go get clothes and put them on to get out of the clothes they're wearing."

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

"They also go to the hotel. We've had kids that have gone to the hotel and ended up in situations that we wouldn't want them to be in again, just based on getting in vehicles and then just going there because that's what they know, and that is their survival skills right there."
"When you talk about it's dangerous to do, because they don't know what they are putting out there or what person may not find them as intriguing as they find themselves. I was surprised how many people would pick these kids up walking down a country road, or if they went the other way, it was a housing development with a golf course, as well – so there was shelter, they would find the different little shelters. Also, because of much more open access to phones and different abilities to communicate, if you're doing work at school and you know how to hack into Facebook and all those different things that you think you have firewalls against, communicating with the outside world, we definitely have kids picked up often in different locations from their friends or family, or acquaintances."

Topic III: What services were provided to the child or youth after a run?

"We also conduct a search and shower, which is basically where they have to turn in all of their clothing that they were off campus with so we can search it. They then have to shower with lice shampoo, because we have had youth who have gone off campus who hang out with some individuals who were homeless and then contracted lice and different things, and then we provide them with facility clothing. Then, there is a big debriefing process, a processing that has to happen to discuss the behaviors and the prior events that caused that behavior, because if we don't know what caused it, we can't help make a safety plan to negate those things."

"When possible – especially if the police brought the client back or if they came back just checking in with them. If they're able to process before going back into the milieu, then great. If they're not, we still at least need to be like, 'Are you going to be able to be safe in the milieu?' Just at least, you know, making sure they're not in any sort of headspace that's going to negatively affect the of the milieu before we bring them back there."

"It's not that we even want them [law enforcement] to be the ones intervening. Often, I'm noticing their techniques and theirs is very compliance-based, and they don't intervene in a way that we would as a trauma-informed facility, so it's not a positive thing whenever we have [law enforcement] being the ones bringing back our kids, or in physical management with our kids. I don't think I've had a time where I've felt very positive or comfortable with the way they intervene, which is not to say that they're doing anything wrong. It's just the way they're trained versus the way we are trained, which is why we try and keep our kids as close to home as possible so that we can prevent as many of these hands-on and spit-masks, and we don't slam kids, but if a kid gets out, like they did this week, and goes to swing at a cop, you're going to get slammed to the ground, and that does happen."

"They don't treat you like, 'Hey, you ran because you had an issue.' It's more like, 'You ran because you're a bad kid. Or you ran away because you needed attention or whatever.' It's not, 'You ran away. What's wrong? Why did you run?' It's never, 'What happened?' It's, 'These are the consequences now.' Consequence after consequence after consequence, to the point where I got put into seclusion. Like it was bad when I got back. I feel like I wasn't treated like a human. I felt like I was treated like an animal, or like a number. I was a stamp, you know, just put in a room to calm down."

"I guess the environment, getting with – getting you sick. If you stay out too long and it's a cold night, you'll get sick. They have illnesses that can happen. Basically, though, it's a natural consequence where you go – you run and you get picked up and go to jail. That's a natural consequence because you did it to yourself where you're getting sick."

"If you're frequented AWOL, you're frequently AWOL, you're like, 'It's not really a big deal. Just come back and get back on the program.' But if you rarely go AWOL people will ask like, 'You need help with anything? Do you need anything?'"

"When I came back from AWOLing, I didn't really get treated any differently. Everybody hated my, like, staff-wise, hated my guts, because I was already acting a fool before that. I already had a whole reputation. I was still treated absolutely horrid. Then I got changed to a different unit, and it was really great there. Anyway, but my thing is, like, staff-wise, staff will do whatever."

Topic IV: What programmatic and systemic barriers make it difficult to prevent a run from occurring?

Defining Imminent Danger

"Some of the neighborhoods that, you know, houses are located in our – we're in [a city] and the kid goes to run and we're not in the greatest neighborhoods, where does that leave us? We have gang kids that we've had where someone – you know, that's affiliated with the gang that they're in… has been killed. And this kid it has talked about paybacks and things like that. So to me that would mean he's a danger to others to others. Right? In that situation. I just think asking some questions about

where that risk lies and where it crosses over to imminent risk is some of the questions that I think need to be asked. At what point does this become an imminent risk to yourself or others?"

"There are competing rights. Kids have the right to leave the facility. I think for a lot of us we also have the view that kids have a right to safety. They have a right to be protected from being trafficked. They have a right to be protected from overdose. They have a right to be protected from being hit by a car on the side of this highway. Like, they are children. We are adults. They need to be protected by us."

"Sometimes, knowing, seeing a kid that's completely out of control, that is completely chaotic, that's saying they're going to run off campus and get hit by a car, at that point, sometimes physical intervention is absolutely needed, because when they can't manage their safety, we will have to intervene and do it for them. Physical intervention, at the end of the day, is an asset to us, to be able to maintain that safety at all points."

"Clearly, this has evolved over the last 20 years that I've been involved. We used to physically intervene with kids that were leaving, and that changed through licensing regulation, or interpretation of the licensing reg, is what I would say, because it says imminent danger and how that is interpreted, I think, is very different with circumstances and the kids that you're working with. I think, over the years, that became a really difficult thing to put into practice. You know, [another provider] just talked about they've added a cost by having to contract with the local police department."

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

Staff Shortage

"I've been asking to talk to some staff here for days now, and the only time they talk to me when I was crying yesterday when I found out my brother, I was gonna lose my brother."

"It's like staff's fault 80, 90 percent of the time, but on other hand, a lot of it isn't because of staff. It's more because there's staff that obviously are mistreating, you know, saying not okay things, all that kind of stuff, but there also are a lot of staff that will try to get your priorities met, but are incapable because there's a staff shortage, and there's only so many of them, and a lot of us."

"It does get really hard when like those people [peers] that are the problems ask to process the staff that you've been waiting to process for days, and they have been trying to get to you. That makes me really upset. Because like I've been waiting for – we're five days now. And there was another youth that asked to process, and then got processed with, which is got really frustrating to me."

> "It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day."

> "Unfortunately, we ebb and flow with staffing patterns in the sense of I feel like we're always green on the direct care staff, but, once again, it goes back to the people that are super good with kids tend to move away from kids. They become administrators and they become case managers, and our direct care staff are the ones that are with the kids all the time, and we definitely see a less experienced person doing the day-to-day, the hard work on the front lines."

Law Enforcement

> "I think that there's just not a good understanding or knowledge of what we do and what our policies are and what we are allowed to do and what we are not allowed to do as well as there are some misconceptions we have about them and what they are able to do and incapable. A lot of it is a communication issue [with law enforcement] and that we are all working in a really sensitive field and there's a lot of pressure put on everyone from every direction who are all nervous about making the wrong decision."

Reporting Requirements to CDHS

> "Even though [the child] did some transgression, something happened. Again, on youth that have histories of delinquency have all of a sudden been more empowered than they were before all that took place. And that's where we all struggled, is, you know, we love kids. We want to work with kids. We want to see them succeed. We want to see them go home and live and live happily ever after. And we work really hard to do that. And then to have the default be you're doing something wrong when you're performing your duty is just backwards. It's completely – makes no sense."

> "The thing that we are really missing is the availability to make our own decision about how we intervene. We're being forced to make a decision based on compliance reasons, and that's just being honest about our situation because we typically – if feel like the scales have an overbalance on this issue of not intervening for compliance-based reasons, and I don't think we should do that. However, I don't think that should be prioritized over the safety risks of the youth leaving in all these intricate, judgmental things that happen after the fact of why you did something, or whatever. My personal opinion is that if we were allowed to monitor our own compliance-based interventions and deal with that, because we don't want to do that, that's not our mode of interacting with kids or our program setup, but everybody is with a magnifying glass judging if we're doing that or not. If we were allowed to monitor that and we were allowed to intervene when we feel like it's an unsafe situation for a kid, we would stop kids from leaving the campus, and we would handle it in our way that we are trained to handle things on the grounds."

Topic V: Opportunities for Prevention: Consequences and Connectedness

Fear of Consequences

"The consequences, because like – You'd lose your privilege for the day, three days. Lose being able to go places. You got all your stuff taken out of your room."

"When I see people who are going AWOL I remind myself I want to go home. I also want to see my family. So I just look on the bright side and don't AWOL."

"If you go AWOL for two hours, right, so two hours you're just out walking around, but like that doesn't add up to three days. Like why would you go AWOL for two hours just to have to lose everything for three days?"

Connectedness to Providers

"The staff will talk me out of it."

"Last night like a staff stopped one of the kids from going AWOL. The staff said, 'No, you're not going to go out that door.'"

"I would say the biggest thing that helped our kids stay put was when they were connected to enough staff that they felt cared about."

"I think we see this very frequently. I think we probably see this more than the kids talking about it and then actually running. Our staff are really trained in de-escalation and processing and co-regulation. And they're able to verbally tell us if they're wanting to run and verbally tell us why, then doing those things to help co-regulate and bring the kid back down has been a huge help."

"I would also say that when a young person tells you they're going to run away, when they're thinking about running away they're looking for – that's a lifeline. They're asking for help. The people that run away typically don't tell you. You might see warning signs but there won't be an outward…yeah. My experience is that when a young person says, 'I'm really thinking about running away,' he's looking for permission to stay and perhaps different support, better support, in the program that he is in or she's in."

"I agree with that. I've seen that a lot too. Like, I've had a client that would literally just say, "I'm going to run," and he'll get down to the end of the hallway but then he'll turn around and make sure staff was – but he never got out of the building. He just wanted to make sure we were following him. So I do feel like there's a lot of just following him around, processing, trying to process within an encouraging them to make the right decisions. And whether that's in their best interest."

Appendix C: Coding Strategy

Phenomenological methodology involves exploring lived experiences of people as experts in their own lives. This type of methodology involves taking a holistic view of the data to understand the phenomenon being studied, in this case lived experiences with running incidents. In this program evaluation process, the PI captured the essence of what it was like to experience a run personally, as a peer who runs, or from the perspective of the service provider. The coding process in this research approach involves the following methods: epoche, phenomenological reduction, horizontalization, imaginative variation, and synthesis of meanings and essence.[1] Each of the following steps occur in order, as the steps are intended to build upon one another, and one cannot happen before the previous step is achieved.[32]

Epoche

This first step means to refrain from holding dogmatic views of the phenomenon being studied. In order to accomplish this step, the PI and external coders evaluated any previously held biases, understandings, or judgements regarding running incidents and behaviors.

Phenomenological Reduction

The phenomenological reduction process involves viewing all participant statements in an open way and aiming to recognize any bias that may hinder the evaluators in fully understanding the participant experience. Methods used to address this were evaluator journals, listening to recorded interviews multiple times, and carefully reviewing interview transcripts.

Horizontalization

This process involves giving each participants' statements equal importance by setting aside evaluator bias or opinion. To accomplish this, the evaluator reviewed transcripts independently and worked with external coders to evaluate accuracy.

Imaginative Variation

Each external coders read transcripts according to the codebook. The PI carefully considered the possible underlying causes or influences that may have impacted participants in their experiences with running from out-of-home placements. The PI and external coders selected salient participant statements to represent the textural essence of the phenomenon that was studied.

Synthesis of Meanings and Essences

This final step in phenomenology is intended to synthesize the meaning and essence through a rich description of the phenomenon. This step is represented in the results section by integrating participant quotes.

Trustworthiness

One evaluator conducted the interviews and evaluated the transcripts. In order to reduce bias, the PI consulted with two qualitative research coders to reduce bias and subjectivity in the data analysis process.[33] Additionally, the PI used five criteria to address trustworthiness: credibility, transferability, dependability, confirmability, and authenticity.[34]

Credibility

Credibility refers to the importance of viewing each participant as an expert in their own life and experiences.[35]

Transferability

Transferability is the extent to which the results of can be applied in other contexts.[36, 37] The quality of transferability depends on the evaluator's ability to describe the evaluation process and findings for the reader to determine its applicability to their context.[38] In this report, findings were represented with direct quotes that support the findings.

Dependability

In qualitative research and evaluation, the concept of dependability is related to whether the data collected is stable over time.[39, 40] This was achieved through documenting all decisions made by the evaluator to the Colorado Action Lab Staff, the Office of Colorado's Child Protection Ombudsman, and the Timothy Montoya Taskforce.

Confirmability

Confirmability refers to ensuring the data and interpretations are accurate. In this project, the findings and interpretations were directly linked to raw data and an audit trail of data.[41, 42]

Authenticity

Authenticity is seen as the ability to represent multiple perspectives in data interpretation.[43, 44] This was accomplished through use of two external coders to review the PI's interpretation of data.

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KEYSTONE POLICY CENTER

2023 INTERIM REPORT

TIMOTHY MONTOYA TASK FORCE

TO PREVENT YOUTH FROM RUNNING FROM OUT-OF-HOME PLACEMENT

House Bill 22-1375

Child Protection Ombudsman of Colorado

Facilitated by: Keystone Policy Center

October 1, 2023

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INTRODUCTION

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

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

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

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

In the fall of 2021, the CPO started working with members of Colorado's General Assembly, Colorado's residential treatment provider community and other stakeholders to draft legislation aimed at addressing youth who run away from their out-of-home placement. This work culminated in the creation of House Bill 22-1375, "Concerning Measures to Improve Outcomes for Those Placed in Out-of-Home Placement Facilities."[1] Sponsored by Rep. Dafna Michaelson Jenet and Sen. Janet Buckner, this bill established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-Of-Home Placement (Task Force). The two-year Task Force was placed within the CPO, which is charged with

[1] See Appendix A, House Bill 22-1375

administering the Task Force and ensuring a neutral and inclusive space for members to carry out their work.

OVERVIEW OF THE TASK FORCE

Charge and Membership

The General Assembly established the Task Force to ensure there was a thorough and thoughtful analysis of the root cause for why children and youth run away from care. Task Force members are charged with analyzing current laws, regulations and practices regarding how providers and agencies respond to children and youth who run away from care. They are also tasked with developing a consistent, prompt, and effective response for when youth run away from care, how to promote their care and well-being upon their return and programs to deter youth from running from care to begin with. In total, the Task Force must address the following eight directives[2]:

1. Analyze the sufficiency of statewide data regarding the experiences of children who have run away from care.
2. Analyze the root cause of why children and youth run away from care.
3. Identify and examine behaviors that constitute running away from care, analyze differences between "runaway" behavior and age-appropriate behaviors outside of the home or out-of-home placement and identify behaviors that should lead to a person or facility filing a missing person report.
4. Analyze the relationship between children and youth who run away from care and the likelihood that the child will become a victim of a crime.
5. Analyze the comprehensiveness and effectiveness of existing state laws, regulations and placement facility protocols to respond to a youth's threat to run away from care and for promptly reporting, locating, evaluating and treating youth who have run away from care.
6. Analyze best practices at both the statewide and national levels for preventing and addressing runaway behavior, including methods to discourage children from running away.
7. Analyze how entities responsible for the care of youth who run away from care can coordinate a thorough and consistent response.
8. Identify the resources necessary to improve or facilitate communication and coordinated efforts among out-of-home placement facilities, county departments of human services and law enforcement agencies regarding children who run away from care.

Based on the assessments above, the Task Force maintains discretion to develop recommendations.

The Task Force is comprised of 24 individuals. These members include young people who previously resided in out-of-home placements, families whose children have run from out-of-home placements, members of law enforcement and professionals who are responsible for the care of youth in out-of-home placements including residential child-care providers, child welfare human service providers, non-profit organizations, foster parents and others.[3] To solicit applications, the CPO launched a statewide campaign though social media and other communications efforts, as well as working directly with organizations and agencies to encourage candidates to apply. Dozens of applications were submitted,

[2] See C.R.S. §19-3.3-111(5)

[3] See Appendix B, Task Force Member Appointment List

and members were selected based on criteria stated in House Bill 22-1375, as well as professional and lived experience.[4] Throughout the past year, the CPO has worked to replace vacancies and continue to fill positions.

Pursuant to House Bill 22-1375, the Child Protection Ombudsman serves as chair of the Task Force and members are charged with selecting a vice-chair. As such, Child Protection Ombudsman Stephanie Villafuerte and Beth McNalley, Program Manager with Denver Public Safety Youth Programs were selected as chair and vice-chair respectively.

Facilitation and Support

The CPO contracted with the Keystone Policy Center (Keystone) to facilitate the Task Force's meetings and provide additional support to members. Keystone is responsible for facilitation and project management, as it relates to the activities of the Task Force. Keystone is responsible for co-designing the process with the CPO office and co-chairs and ensuring the Task Force runs smoothly, including promoting full participation of all Task Force members and – when possible – helping the parties resolve their differences and work toward resolving concerns. Working with task force members, Keystone will ensure adequate and coordinated stakeholder engagement that will be essential to the task force meeting its goals. Keystone worked with Task Force members to develop a working charter for member.[5] This charter provides members with guidance regarding the charge of the Task Force, ground rules for engagement and standards for media engagement.

Voting Structure

The Task Force operates under the understanding that its findings and recommendations do not necessitate consensus among its members. Instead, the Task Force aims to ensure an accurate representation of its collective views. While consensus is not the primary goal, the Task Force strives to capture the diverse opinions and robust discussions by taking polls and making note of individual perspectives to inform its recommendations comprehensively. These discussions and findings are captured in written summaries of each meeting, meeting minutes and the two reports required by law.[6]

Transparency

All meetings are open to the public, welcoming valuable input and insights from attendees. Pursuant to House Bill 22-1375, the CPO works with Keystone to promote each meeting by sending out media advisories and posting information about each meeting on the CPO's website. In addition to inviting members of the public to present during various meetings, information shared during public comment often shapes the topics raised for discussion or inspires ideas to explore further. Consistently, 10 to 25 members of the public attend Task Force meetings, as well as media outlets. Additionally, each meeting is recorded, and those recordings are posted to the CPO's website for anyone to review. Meeting materials, meeting summaries and other materials are also posted to the CPO's website.[7]

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[4] C.R.S. §19-3.3-111(3)

[5] See Appendix C, Timothy Montoya Task Force to Prevent Children form Running Away from Out-of-Home Placement Charter

[6] See C.R.S. §19-3.3-111(7)

[7] See CPO's website, Timothy Montoya Taks Force to Prevent Youth from Running from Out-of-Home Placement

FIRST YEAR SUMMARY

To date, the Task Force has met nine times:

- September 28, 2022
- November 2, 2022
- January 4, 2023
- March 1, 2023
- April 12, 2023
- May 3, 2023
- June 14, 2023
- July 12, 2023
- August 9, 2023

While House Bill 22-1375 only requires the Task Force to meet every other month, members opted to begin meeting monthly to ensure there is adequate time to address each directive and develop thoughtful recommendations before the Task Force concludes. Discussions during the first year were structured around directives provided in House Bill 22-1375 and input from members. In addition to research conducted by CPO staff, with support from Keystone, a diverse array of speakers, presenters and panels were carefully selected to ensure a comprehensive representation of ideas, perspectives, experiences, knowledge and information pertaining to the subject matter. Most importantly, the Task Force's syllabus is designed to remain flexible and responsive to the needs of the Task Force in addressing each directive.

During its first year, the Task Force has focused its discussions on four key areas: (1) Exploring Qualitative Data and the root causes of why youth run away from care; (2) Evaluating current law and rules for vagueness and gaps; (3) Assessing the availability of quantitative data regarding youth who run from care; and (4) Developing standard responses for after youth they run away from care. There are several members who have stated the need to begin developing methods for preventing youth from running away. Such methods have generally been discussed in two areas. The first is creating a safety plan for youth upon admission to a facility, as well as providing education and resources regarding run away behavior. The second centers on physically preventing youth from running away from care. Members have suggested a variety of mechanisms, including locked or time-delayed doors, utilizing electronic monitoring or, in the most severe circumstances, restraining youth attempting to run away. Members have widely acknowledged that a deep discussion and analysis of the law regarding such restraints will have to take place as well.

As the Task Force enters its second year, efforts to develop standard responses will merge with discussion on prevention efforts.

At the conclusion of its first year, the Task Force opted not to issue recommendations. This is in large part because the majority of members have stated additional information and discussion is needed before the Task Force may issue thoughtful recommendations. However, the Task Force has reached agreement regarding gaps in current systems, and strategies for addressing those needs. These findings and strategies are detailed below.

Use of the Term "Runaway"

Prior to diving into discussions, the Task Force took time to consider the language members would use and terms that will be used in reports. This conversation centered on the use of the term "runaway." Multiple members and presenters highlighted issues with this term, particularly in the context of

children missing from care. The term is seen by some as problematic because it places responsibility on the child and overlooks the complex factors that may lead them to leave care, including coercion by external parties and a youth's behavioral health considerations. It was suggested that a more suitable replacement term is "children missing from care." The discussion underscored how the term "runaway" perpetuates negative stereotypes about these children and fails to capture the complexity of their situations. The group opted for a middle ground by using language that prioritizes the child as an individual, such as "a youth who has run away from care" to promote a more empathetic and accurate way of describing them. This approach has been incorporated into the Task Force's discussions and reports.

First Year Discussions and Findings

1. ***Exploring Qualitative Data and the Root Causes of Why Youth Run Away from Care***

   The Task Force placed value on collecting both quantitative and qualitative data to gain a comprehensive understanding of why youth run away from care. Qualitative data is seen as crucial for addressing complex public policy problems and formulating effective solutions. However, there was a recognition by the majority of members that existing qualitative data at the statewide level is inadequate, and there is a strong interest in obtaining more in-depth qualitative insights from youth and former youth who have experienced running away from care. The Task Force evaluated currently available qualitative data – and the need for more consistent access to qualitative data – through four primary discussions.

   a. Lived Experience Panel Discussion

      The Task Force invited individuals who have experienced out-of-home placements, and in some instances those who have run away from care, to share their experiences and insights. Members engaged with two groups of guest speakers who shared their lived experiences. Foster parents and child protection professionals on the first panel spoke about youth running away from their care and the perspective that gave them. Each of the panelists on the first panel expressed a desire for more resources to care for the mental health and behavioral heath needs of the youth in their care. Additionally, all called for a stronger sense of urgency when a youth runs away. The second panel featured adults who ran away from their out-of-home placements as youth, and they discussed their individual experiences in the child protection system and what caused them to run. All the panelists on the second panel recalled their desire to return to their homes and/or parents, regardless of the circumstances.

   b. Provider Panel Discussion

      The Task Force also heard from a panel of providers. During this discussion, various challenges faced by providers in out-of-home placement were highlighted. These challenges encompassed safety concerns, the importance of understanding why youth run away, and the need for positive, relational approaches to prevention. The panel collectively identified key challenges, including the necessity for staff training to engage positively with youth,

inconsistent response from law enforcement and a lack of guidance from the Colorado Department of Human Services (CDHS) regarding the use of restraints and responding after youth run away from care.

Task Force members engaged with the panel by discussing responses to youth attempting to run away and recognizing the significance of understanding common triggers for such behavior. There was also discussion about potential legislative changes to address safety concerns and the importance of enhancing training and support for kinship and foster homes.

c. Commissioned Report

Pursuant to House Bill 22-1375, the CPO was charged with contracting with an institution of higher education to conduct focus groups with children and youth in out-of-home placements and providers to determine "what conditions lead children to run away from out-of-home placement, the provider's efforts to locate children who have run away, and the services provided to a runaway child upon the child's return."[8] The CPO selected the University of Denver's Colorado Evaluation and Action Lab (the Action Lab) to administer the focus group and produce the correlating report.

Dr. Kristin Myers with the Action Lab presented highlights from the commissioned report aimed at providing a more comprehensive understanding of the issue of youth running away from care.[9] The report captures the experiences of youth who run away, including their reasons for running and why they returned. It was a collaborative effort involving staff at residential child care facilities and youth currently residing at such facilities. The data and findings aligned with ongoing discussions within the Task Force. The research involved providers and youth from different regions in Colorado, with interviews being recorded and transcribed for analysis.

The report identified several factors contributing to youth running away, including trauma triggers, the search for familiarity or connection, and impulsive adolescent behavior. Dr. Meyers emphasized the significance of understanding the complex reasons behind running incidents and the role of connectedness in prevention, intervention and aftercare. She highlighted the dysregulation experienced by youth during runs and their desire for autonomy. Collaboration between state agencies and providers was emphasized to define imminent danger and develop effective prevention strategies.

In the discussion that followed, members expressed their lack of surprise regarding the report's findings but highlighted the absence of emphasis on peer pressure and group runaway tendencies among youth. Dr. Meyers acknowledged this observation, explaining that while peer pressure was mentioned, it wasn't a major theme in the conversation.

[8] See C.R.S. §19-3.3-11(6)(a)

[9] See Appendix D, *Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements*, University of Denver Colorado Evaluation & Action Lab, April 1, 2023.

Members also commented on the report's organization and appreciated the inclusion of the unexpected behavior of adolescents. They raised questions about the types of placements discussed and the potential influence of gangs, which Dr. Meyers addressed by explaining the focus of the study and the challenges of obtaining complete honesty from youth.

Members generally agreed that the report is a valuable resource for understanding the problem of runaway youth in out-of-home placements. The discussions spawned some ideas and suggestions, among which were that the data collection process be improved and that the results be shared more regularly, that data on individual-level interventions be evaluated, and explore the use of peer supports and counseling for runaway youth. Members agreed that conducting focus groups such as these should be done on a regular basis, and the experiences provided by youth and employees working at facilities should be presented regularly to the public and the Colorado General Assembly. Members also discussed forming partnerships between agencies enhance access to data and improve how data is entered into Trails.[10]

d. National Predictors of Running Away from Care

Dr. Tara Richards and Caralin Branscum, PhD student, School of Criminology and Criminal Justice, University of Nebraska Omaha presented their study: "*An updated examination of the predictors of running away from foster care in the United States and trends over ten years (2010–2019)*."[11] The study examined the factors associated with children running away from foster care. The study found that removal from the home due to a child's substance abuse problems was strongly associated with an increased risk of running away, as was abandonment and behavioral problems. Neglect was also found to increase the likelihood of running away, albeit to a lesser degree. In contrast, children who were removed from the home due to parental substance abuse or a disability were less likely to run away compared to children who did not experience these issues. The study also identified several other factors associated with an increased risk of running away, including geographic location, placement instability, and certain behavioral health diagnoses. The findings of the study suggest that there are complex reasons why children run away from care, and that intervention strategies need to be tailored to the specific risk factors associated with each child.

Members discussed the value of collecting demographic data for children and youth at a high risk of running away from care. However, several members – particularly providers – stated that the use of such predictors will be unlikely to identify youth who will run away and unhelpful in preventing them from doing so. This is largely because collecting all the necessary information to make such predictions is challenging.

[10] Trails is the statewide child welfare database.

[11] See Appendix E, *An updated examination of the predictors of running away from foster care in the United States over ten years (2010-2019)*, Caralin Branscum, M.S., Tara N. Richards, Ph.D., University of Nebraska, January 24, 2022

2. Evaluating Current Law and Rules for Vagueness and Gaps

Various members representing county departments of human services, providers and law enforcement presented the policies and procedures that are typically followed when a child or youth goes missing from care. Members highlighted challenges facing each profession when responding to children or youth who run away from care. These included variations in these procedures based on factors that are specific to each jurisdiction. All professions noted the difficulty in maintaining continuity of information can be challenging in cases of caseworker turnover.

Chair Villafuerte provided an overview of federal and state laws and regulations that determine reporting requirements and protocols when youth run away from care. These requirements determine the data that is collected and reported. The federal law requires states to develop and implement specific protocols for dealing with missing youth, such as immediately reporting and locating missing youth, as well as determining the factors that contributed to them running away and their experiences while absent from care. Certain provisions of Title 19 of the Colorado Revised Statutes (Children's Code) and Volume 7 of the Colorado Code of Regulations (Social Services Rules Staff Manual Volume 7; Child 1 Welfare, Child Care Facilities) guide the response to youth who run away from out of home care.

Members discussed several challenges and issues related to children running away from care, including:

- Data Documentation in Trails Database – Caseworkers document essential information about a child's experience, including reasons for running away, in the Trails database. However, this data is in narrative form, making it challenging to extract patterns and hinder prevention efforts.
- Lack of Closure Guidance – State law and regulations lack clear guidance on when Human Service cases can be closed. Some jurisdictions close cases sooner than others, potentially resulting in the loss of valuable data for assessing runaway experiences. A payroll rule restricts payment for placement when the youth is absent for more than seven days.
- Focus on Anti-Trafficking Efforts – Existing regulations primarily emphasize anti-trafficking efforts when addressing runaway children. This focus overlooks other factors that may lead a child to run away, such as exposure to criminal activity or behavioral health disorders. More distinct guidance and regulations are needed to address diverse runaway reasons.
- Duty to Report, Not Locate – There is no obligation to actively locate youth who run away; the duty is limited to reporting. Funding streams for providers do not allow them to search for missing children, leading to immediate case closures when a child leaves home. This lack of provision hinders efforts to identify a child's whereabouts or prepare for their return.

3. Assessing the Availability of Quantitative Data Regarding Youth Who Run Away from Care

The Task Force is charged with analyzing the effectiveness of statewide data that measures the quantitative and qualitative experiences of children and youth who run away from care. To assess this directive, members heard from the CDHS regarding current practices for capturing data about children and youth who run away from care. This data includes the number of incidents that are reported and the total number of children entering "runaway status" and the duration of the time they were away. Members also learned how providers in the state work to track the same figures.

Ultimately, the majority of members agreed that current, statewide data is insufficient and there is a need for standard data entry practices and consistent data extraction methods. The majority of members agreed that data should be able to demonstrate the "why" behind children and youth who run away from care. Finally, there was agreement among members that data currently does not capture attempted or available interventions.

Members also noted that existing data primarily provides information about the volume of youth who run away, but lacks actionable insights, making it difficult to address the issue effectively. Key questions regarding the experiences of youth while they are on the run remain unanswered, hindering a comprehensive understanding of the problem. Members highlighted the importance of comparing the volume of children who run away from out-of-home placements to the number of children who run away from the primary caregivers, as this could provide valuable insights. The current data does not differentiate between different types of placements, abuse, neglect, or other factors that could be analyzed to identify trends and patterns.

To address these limitations, there was a suggestion to conduct a check-the-box analysis of the Trails database and initiate a detailed, time-limited study of each child who runs away within a specific timeframe to gather more detailed and actionable information. Another significant challenge identified was the absence of a statewide system for uniform information gathering or a standard tool for assessing youth upon their return from running away. This gap makes it difficult to comprehensively address the issue.

The importance of gathering information from providers when youth leave was emphasized, as this data can shed light on the circumstances surrounding their departure. Additionally, discussions delved into barriers related to locking facilities and the effectiveness of trauma-informed care in addressing the issue of runaway children. Members also stressed the significance of intentional placement and location of youth, as well as the need to establish comprehensive plans from the outset to prevent them from running away. It was noted that involving youth directly in discussions and considering the effectiveness of phone check-ins versus face-to-face meetings could provide valuable insights.

Furthermore, tracking successful caseworker strategies for locating youth who run away from care and incorporating them into training programs was discussed as a potential solution. Sharing information between partner organizations, particularly between CDHS, county departments of human services and law enforcement, was considered crucial for addressing the

issue effectively. Lastly, there was a call for data to be broken down by county and facility to identify common themes and patterns, allowing for more targeted interventions and solutions to prevent runaway incidents.

4. Developing Standard Responses for After Youth Run Away from Care

Task Force members who represent county departments of human services, providers and law enforcement presented the policies and procedures that are typically followed when a child goes missing from care. Specific challenges with each step were highlighted, including variations in these procedures based on factors such as the type of facility, county practices, and available resources.

Adding to this context, the Task Force also studied research from all 50 states regarding how they address the issue of youth who run away from care. Child Protection Ombudsman Villafuerte highlighted differences in reporting criteria among states and gave examples of other states having specific response criteria based on youth vulnerability. For example, some states have created definitions that require community agencies to respond immediately when certain categories of youth run away from care. Colorado currently lacks such a detailed response structure, prompting discussion about the need for a comprehensive practice manual. Some states, like the District of Columbia, Texas and Tennessee, have *absconder units* within human services departments with low, moderate, and high priority responses for locating youth who have run away from care.[12] Members dedicated the meetings held in June, July and August to discussions about how to create standard responses for when youth run away from care. Members completed a survey to define age-appropriate behavior and circumstances that should warrant filing a missing person's report. They were also surveyed about criteria for different levels of response and which entities should be involved in those responses.

During the August 2023 meeting, the majority of members voted to continue developing the following concepts:

- A statewide response team for when youth run away from care.
- A set of statewide, standard guidelines for responding to youth who run away from care. These guidelines could include protocols for human services departments, facilities and law enforcement.
- Temporary placements for youth who are located after running away from care.

Several members have stated that additional information is needed as the group continues to develop these concepts. The Task Force has not yet decided if it will issue recommendations regarding these proposals. However, the group will continue to analyze research and experts as it makes those determinations. Additionally, members have agreed that the second year of the Task Force must include discussion regarding prevention efforts. During the second year,

[12] Members were provided with materials detailing such practice in Tennessee, Texas and Washington, D.C. Those materials may be accessed by clicking HERE.

members will hear from experts who have studied youth runaway behavior nationally. They will also be presented with research capturing state laws that allow – or prevent – facilities from using physical infrastructure to prevent youth from running away.

Collectively, members will use this information to determine any findings or recommendations. The Task Force will present its final work in a report issued no later than October 1 ,2024.

CONCLUSION

During the past ten months, the dedicated members of the Task Force have engaged in a meticulous and collaborative process to examine the complex and sensitive issue of children and youth running away from care. Their approach has been marked by a commitment to inclusivity, fostering open discussions, and harnessing the wealth of experiences and perspectives within our diverse team.

The journey began with a comprehensive alignment and level-setting phase, where members came together to establish a common understanding of the issue, its underlying causes, and the impact of current laws and policies. This initial step was essential in bridging the various backgrounds and expertise present within the task force, ensuring that everyone was on the same page before diving into the substantive work ahead.

Throughout this initial phase of the Task Force, each member's unique experiences and perspectives were brought to bear on the issue at hand. These conversations not only enriched the collective understanding but also led to the emergence of ideas and solutions that might not have been uncovered in isolation. It was through this collaborative exchange that the group fostered a sense of unity and purpose in the mission.

The task force's initial findings, encapsulated in this report, are not set in stone; rather, they serve as a foundation for further refinement. In the coming months, we look forward to refining our recommendations, building upon the collective wisdom and insights of the task force. The ultimate goal is to develop a comprehensive and empathetic approach that will better serve the needs of these vulnerable children and ensure that they receive the support, care, and understanding they deserve.

Pursuant to C.R.S. §19-3.3-111(7)(a), the Task Force respectfully submits its interim report.

APPENDIX A

House Bill 22-1375

HOUSE BILL 22-1375

BY REPRESENTATIVE(S) Michaelson Jenet, Amabile, Bacon, Bird, Cutter, Duran, Esgar, Exum, Froelich, Gonzales-Gutierrez, Herod, Kennedy, Lindsay, Lontine, McCluskie, McLachlan, Mullica, Ricks, Titone, Valdez A., Woodrow, Young, Sirota;
also SENATOR(S) Buckner, Fields, Ginal, Lee, Zenzinger.

CONCERNING MEASURES TO IMPROVE THE OUTCOMES FOR THOSE PLACED IN OUT-OF-HOME PLACEMENT FACILITIES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

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

SECTION 1. In Colorado Revised Statutes, **add** 19-3.3-111 as follows:

19-3.3-111. Task force to prevent youth from running from out-of-home placement - creation - membership - duties - report - definitions - repeal. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CHILD" MEANS A PERSON UNDER EIGHTEEN YEARS OF AGE.

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.

(b) "CHILDREN WHO HAVE RUN AWAY" MEANS A CHILD WHO HAS LEFT AND REMAINS AWAY FROM OUT-OF-HOME PLACEMENT WITHOUT THE PERMISSION OF THE CHILD'S PARENT, CAREGIVER, OR LEGAL GUARDIAN.

(c) "INSTITUTION OF HIGHER EDUCATION" MEANS A POSTSECONDARY INSTITUTION THAT ENTERS INTO AN AGREEMENT WITH THE CHILD PROTECTION OMBUDSMAN TO PERFORM RESEARCH AND CONDUCT FOCUS GROUPS.

(d) "OUT-OF-HOME PLACEMENT" MEANS PLACEMENT IN A RESIDENTIAL CHILD CARE FACILITY OR FOSTER CARE HOME, AS EACH IS DEFINED IN SECTION 26-6-102.

(e) "OUT-OF-HOME PLACEMENT PROVIDER" OR "PROVIDER" INCLUDES A LICENSED OUT-OF-HOME PLACEMENT PROVIDER AND A FOSTER PARENT APPROVED BY A COUNTY DEPARTMENT OF HUMAN OR SOCIAL SERVICES.

(f) "TASK FORCE" MEANS THE TIMOTHY MONTOYA TASK FORCE TO PREVENT CHILDREN FROM RUNNING AWAY FROM OUT-OF-HOME PLACEMENT ESTABLISHED IN THIS SECTION.

(2) (a) THERE IS CREATED IN THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN THE TIMOTHY MONTOYA TASK FORCE TO PREVENT CHILDREN FROM RUNNING AWAY FROM OUT-OF-HOME PLACEMENT. THE TASK FORCE IS ESTABLISHED TO ANALYZE THE ROOT CAUSES OF WHY CHILDREN RUN AWAY FROM OUT-OF-HOME PLACEMENT; DEVELOP A CONSISTENT, PROMPT, AND EFFECTIVE RESPONSE TO RECOVER MISSING CHILDREN; AND ADDRESS THE SAFETY AND WELL-BEING OF A CHILD UPON THE CHILD'S RETURN TO OUT-OF-HOME PLACEMENT.

(b) THE OFFICE SHALL ENTER INTO AN AGREEMENT WITH AN INSTITUTION OF HIGHER EDUCATION WITH EXPERIENCE IN CHILD WELFARE RESEARCH TO PERFORM RESEARCH TO SUPPORT THE TASK FORCE'S WORK AND CONDUCT THE FOCUS GROUPS DESCRIBED IN SUBSECTION (6) OF THIS SECTION.

(3) (a) THE TASK FORCE CONSISTS OF THE FOLLOWING MEMBERS:

(I) THE CHILD PROTECTION OMBUDSMAN, OR THE OMBUDSMAN'S DESIGNEE;

(II) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(III) A REPRESENTATIVE OF THE DIVISION OF YOUTH SERVICES WITHIN THE STATE DEPARTMENT OF HUMAN SERVICES, APPOINTED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES;

(IV) A REPRESENTATIVE OF THE DIVISION OF CHILD WELFARE WITHIN THE STATE DEPARTMENT OF HUMAN SERVICES, APPOINTED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES;

(V) THE DIRECTOR OF THE OFFICE OF THE CHILD'S REPRESENTATIVE, OR THE DIRECTOR'S DESIGNEE;

(VI) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC SAFETY, OR THE EXECUTIVE DIRECTOR'S DESIGNEE; AND

(VII) THE FOLLOWING MEMBERS, APPOINTED BY THE CHILD PROTECTION OMBUDSMAN:

(A) TWO MEMBERS WHO REPRESENT A COUNTY DEPARTMENT OF HUMAN OR SOCIAL SERVICES THAT DELIVERS CHILD WELFARE SERVICES, ONE WHO MUST BE FROM AN URBAN COUNTY AND THE OTHER FROM A RURAL COUNTY;

(B) A REPRESENTATIVE FROM A STATEWIDE ORGANIZATION THAT SUPPORTS VICTIMS OF HUMAN TRAFFICKING;

(C) A REPRESENTATIVE FROM A STATEWIDE ASSOCIATION THAT REPRESENTS DIRECTORS OF COUNTY HUMAN OR SOCIAL SERVICES AGENCIES;

(D) TWO FOSTER PARENTS CERTIFIED BY A COUNTY DEPARTMENT OF HUMAN OR SOCIAL SERVICES;

(E) TWO KINSHIP PROVIDERS CERTIFIED BY A COUNTY DEPARTMENT OF HUMAN OR SOCIAL SERVICES;

(F) A REPRESENTATIVE OF A STATEWIDE ASSOCIATION THAT REPRESENTS CHILD PLACEMENT AGENCIES, AS DEFINED IN SECTION 26-6-102;

(G) A REPRESENTATIVE OF A STATEWIDE ASSOCIATION OF FAMILY AND CHILDREN'S AGENCIES;

(H) A REPRESENTATIVE OF AN OUT-OF-HOME PLACEMENT PROVIDER THAT SERVES CHILDREN IN THE CHILD WELFARE SYSTEM;

(I) A YOUNG ADULT WHO IS UNDER TWENTY-TWO YEARS OF AGE WHO HAS EXPERIENCED RESIDENTIAL CARE PLACEMENT;

(J) TWO MEMBERS WHO ARE A PARENT OR FAMILY MEMBER OF A CHILD WHO HAS RUN AWAY FROM OUT-OF-HOME PLACEMENT;

(K) A REPRESENTATIVE OF A NONPROFIT ORGANIZATION THAT SERVES CHILDREN OR YOUTH WHO HAVE RUN AWAY FROM OUT-OF-HOME PLACEMENT;

(L) A REPRESENTATIVE OF THE CHIEFS OF POLICE, RECOMMENDED BY THE PRESIDENT OF A STATEWIDE ORGANIZATION REPRESENTING THE CHIEFS OF POLICE; AND

(M) TWO REPRESENTATIVES OF POLICE OFFICERS, ONE OF WHOM MUST BE FROM A RURAL JURISDICTION AND ONE OF WHOM MUST BE FROM AN URBAN JURISDICTION, BOTH RECOMMENDED BY THE PRESIDENT OF A STATEWIDE ORGANIZATION REPRESENTING POLICE OFFICERS.

(b) (I) IN MAKING APPOINTMENTS PURSUANT TO SUBSECTION (3)(a)(VII) OF THIS SECTION, THE CHILD PROTECTION OMBUDSMAN SHALL SELECT MEMBERS WHO REPRESENT DIVERSE GEOGRAPHIC LOCATIONS, RACE AND ETHNICITY, GENDER, RELIGION, AND SOCIOECONOMIC STATUS.

(II) THE APPOINTING AUTHORITIES SHALL MAKE THEIR APPOINTMENTS ON OR BEFORE SEPTEMBER 1, 2022. THE TERM OF THE APPOINTMENT IS FOR THE DURATION OF THE TASK FORCE. THE APPOINTING AUTHORITY SHALL FILL ANY VACANCY SUBJECT TO THE SAME QUALIFICATIONS AS THE INITIAL APPOINTMENT.

(c) EACH MEMBER OF THE TASK FORCE SERVES WITHOUT COMPENSATION. MEMBERS APPOINTED PURSUANT TO SUBSECTIONS (3)(a)(VII)(D), (3)(a)(VII)(E), (3)(a)(VII)(I), AND (3)(a)(VII)(J) OF THIS SECTION MAY BE REIMBURSED FOR REASONABLE EXPENSES INCURRED WHILE

SERVING ON THE TASK FORCE.

(d) THE CHILD PROTECTION OMBUDSMAN, OR THE OMBUDSMAN'S DESIGNEE, IS THE CHAIR OF THE TASK FORCE. AT ITS FIRST MEETING, THE TASK FORCE SHALL SELECT A VICE-CHAIR FROM AMONG ITS MEMBERS. THE CHAIR AND THE VICE-CHAIR SERVE FOR THE DURATION OF THE TASK FORCE.

(4) THE CHILD PROTECTION OMBUDSMAN SHALL CONVENE THE FIRST MEETING OF THE TASK FORCE NO LATER THAN OCTOBER 1, 2022. THE TASK FORCE SHALL MEET AT LEAST ONCE EVERY TWO MONTHS UNTIL THE TASK FORCE SUBMITS ITS FINAL REPORT DESCRIBED IN SUBSECTION (7)(b) OF THIS SECTION, AND ADDITIONALLY AT THE CALL OF THE CHAIR AS NECESSARY TO COMPLETE ITS DUTIES. THE TASK FORCE MAY MEET ELECTRONICALLY. THE OFFICE SHALL PROVIDE STAFF SUPPORT NECESSARY FOR THE ADVISORY GROUP TO CARRY OUT ITS DUTIES. AT THE REQUEST OF THE TASK FORCE, THE INSTITUTION OF HIGHER EDUCATION SHALL PERFORM RESEARCH TO SUPPORT THE TASK FORCE'S WORK.

(5) THE TASK FORCE SHALL:

(a) ANALYZE THE SUFFICIENCY OF STATEWIDE DATA THAT MEASURES THE QUANTITATIVE AND QUALITATIVE EXPERIENCES OF CHILDREN WHO HAVE RUN AWAY FROM OUT-OF-HOME PLACEMENT;

(b) ANALYZE THE ROOT CAUSES OF WHY CHILDREN RUN AWAY FROM OUT-OF-HOME PLACEMENT;

(c) IDENTIFY AND ANALYZE BEHAVIORS THAT CONSTITUTE RUNNING AWAY FROM OUT-OF-HOME PLACEMENT, ANALYZE DIFFERENCES BETWEEN RUNAWAY BEHAVIOR AND AGE-APPROPRIATE BEHAVIORS OUTSIDE OF THE HOME OR OUT-OF-HOME PLACEMENT, AND IDENTIFY BEHAVIORS THAT SHOULD LEAD TO A PERSON OR FACILITY FILING A MISSING PERSON REPORT ABOUT A CHILD;

(d) ANALYZE THE RELATIONSHIP BETWEEN CHILDREN WHO HAVE RUN AWAY FROM OUT-OF-HOME PLACEMENT AND THE LIKELIHOOD THAT THE CHILD WILL BECOME A VICTIM OF CRIME;

(e) ANALYZE THE COMPREHENSIVENESS AND EFFECTIVENESS OF EXISTING STATE LAWS AND REGULATIONS, AND PLACEMENT FACILITY

PROTOCOLS, TO RESPOND TO A CHILD'S THREAT TO RUN AWAY FROM OUT-OF-HOME PLACEMENT AND FOR PROMPTLY REPORTING, LOCATING, EVALUATING, AND TREATING CHILDREN WHO HAVE RUN AWAY;

(f) ANALYZE BEST PRACTICES STATEWIDE AND NATIONALLY FOR PREVENTING AND ADDRESSING RUNAWAY BEHAVIOR, INCLUDING IDENTIFYING METHODS TO DETER CHILDREN FROM RUNNING AWAY FROM OUT-OF-HOME PLACEMENT;

(g) ANALYZE HOW ENTITIES RESPONSIBLE FOR THE CARE OF CHILDREN WHO RUN AWAY FROM OUT-OF-HOME PLACEMENT CAN COORDINATE A THOROUGH AND CONSISTENT RESPONSE TO RUNAWAY BEHAVIORS;

(h) IDENTIFY RESOURCES NECESSARY TO IMPROVE OR FACILITATE COMMUNICATION AND COORDINATED EFFORTS RELATED TO CHILDREN WHO RUN AWAY FROM OUT-OF-HOME PLACEMENT AMONG OUT-OF-HOME PLACEMENT FACILITIES, COUNTY DEPARTMENTS OF HUMAN OR SOCIAL SERVICES, AND LAW ENFORCEMENT AGENCIES; AND

(i) AT ITS DISCRETION, DEVELOP RECOMMENDATIONS TO REDUCE THE NUMBER OF CHILDREN WHO RUN AWAY FROM OUT-OF-HOME PLACEMENT AND INCLUDE THE RECOMMENDATIONS IN ITS REPORTS DESCRIBED IN SUBSECTION (7) OF THIS SECTION.

(6) (a) THE INSTITUTION OF HIGHER EDUCATION SHALL CONDUCT FOCUS GROUPS WITH CHILDREN IN OUT-OF-HOME PLACEMENT AND YOUNG ADULTS UNDER TWENTY-TWO YEARS OF AGE WHO HAVE AGED OUT OF THE CHILD PROTECTION SYSTEM TO ASSIST THE TASK FORCE IN FULFILLING ITS DUTIES. THE INSTITUTION SHALL CONDUCT FOCUS GROUPS WITH OUT-OF-HOME PLACEMENT PROVIDERS TO DETERMINE WHAT CONDITIONS LEAD CHILDREN TO RUN AWAY FROM OUT-OF-HOME PLACEMENT, THE PROVIDER'S EFFORTS TO LOCATE CHILDREN WHO HAVE RUN AWAY, AND THE SERVICES PROVIDED TO A RUNAWAY CHILD UPON THE CHILD'S RETURN.

(b) THE INSTITUTION OF HIGHER EDUCATION SHALL ASK EACH FOCUS GROUP TO CONSIDER:

(I) THE REASONS WHY CHILDREN RUN AWAY FROM OUT-OF-HOME PLACEMENT;

(II) OPPORTUNITIES AND RESOURCES THAT COULD PREVENT CHILDREN FROM RUNNING AWAY FROM OUT-OF-HOME PLACEMENT; AND

(III) RESOURCES THAT CHILDREN NEED TO ENSURE THEIR SAFETY AND WELL-BEING AFTER THEY RETURN TO OUT-OF-HOME PLACEMENT.

(c) THE OFFICE SHALL REIMBURSE EACH FOCUS GROUP PARTICIPANT WHO IS A CHILD OR YOUTH FOR THE PARTICIPANT'S REASONABLE EXPENSES INCURRED FOR PARTICIPATING IN A FOCUS GROUP.

(d) THE INSTITUTION OF HIGHER EDUCATION SHALL MAKE INFORMATION LEARNED FROM THE FOCUS GROUPS PUBLICLY AVAILABLE AND SHALL SUBMIT ITS FINDINGS TO THE TASK FORCE ON OR BEFORE APRIL 1, 2023. PERSONALLY IDENTIFIABLE INFORMATION ABOUT THE PERSONS WHO PARTICIPATED IN A FOCUS GROUP IS CONFIDENTIAL AND THE INSTITUTION SHALL NOT MAKE PUBLIC ANY PERSONALLY IDENTIFIABLE INFORMATION.

(7) (a) ON OR BEFORE OCTOBER 1, 2023, THE TASK FORCE SHALL SUBMIT A FIRST-YEAR STATUS REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND THE HOUSE OF REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES. THE FIRST-YEAR STATUS REPORT MUST INCLUDE A SUMMARY OF THE TASK FORCE'S WORK AND THE TASK FORCE'S INITIAL FINDINGS AND RECOMMENDATIONS, IF AVAILABLE.

(b) ON OR BEFORE OCTOBER 1, 2024, THE TASK FORCE SHALL SUBMIT A FINAL REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND THE HOUSE OF REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES, THAT INCLUDES A SUMMARY OF THE TASK FORCE'S WORK AND THE TASK FORCE'S RECOMMENDATIONS, IF APPLICABLE.

(8) THIS SECTION IS REPEALED, EFFECTIVE JUNE 30, 2025.

SECTION 2. Appropriation. For the 2022-23 state fiscal year, $99,500 is appropriated to the judicial department for use by the office of the child protection ombudsman. This appropriation is from the general

fund. To implement this act, the office may use this appropriation for program costs.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Steve Fenberg
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED June 7th at 3:10 p.m.
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

APPENDIX B

Task Force Membership List

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

Membership List

Effective September, 2023

Appointment	Name	Organization/Experience
The Child Protection Ombudsman, or the Ombudsman's designee (See C.R.S. §19-3.3-11(3)(a)(I))	Stephanie Villafuerte	Colorado Child Protection Ombudsman, Office of Colorado Child Protection Ombudsman
The Executive Director of the Department of Human Services, or the Executive Director's designee (See C.R.S. §19-3.3-11(3)(a)(II))	Dr. Renée Marquardt	Chief Medical Officer, Colorado Department of Human Services
A representative of the Division of Youth Services within the State Department of Human Services, appointed by the Executive Director of the Department of Human Services (See C.R.S. §19-3.3-11(3)(a)(III))	David E. Lee	Western Region Director, Division of Youth Services
A representative of the Divion of Child Welfare within the State Department of Human Services, appointed by the Executive Director of the Department of Human Services (See C.R.S. §19-3.3-11(3)(a)(IV))	Dennis Desparrois	Provider Services Manager, Colorado Department of Human Services
The Director of the Office of the Child's Representative, or the Director's designee (See C.R.S. §19-3.3-11(3)(a)(V))	Ashley Chase	Staff Attorney and Legislative Liaison, Office of the Child's Representative
The Executive Director of the Department of Public Safety, or the Executive Director's designee (See C.R.S. §19-3.3-11(3)(a)(VI))	Kelly Abbott	OAJJA Manager, Colorado Department of Public Safety

A representative of a rural county department of human or social services that delivers child welfare services (See C.R.S. §19-3.3-11(3)(a)(VII)(A)	Lynette Overmeyer	Child Welfare Assessment Manager, Mesa County Department of Human Services
A representative of an urban county department of human or social services that delivers child welfare services (See C.R.S. §19-3.3-11(3)(a)(VII)(A)	Michelle Bradley	Ongoing Supervisor, Douglase County Department of Human Services
A representative from a statewide organization that supports victims of human trafficking (See C.R.S. §19-3.3-11(3)(a)(VII)(B)	Beth McNalley	Beth McNalley, Program Manager, Safety Youth Programs, City and County of Denver
A representative from a statewide association that represents directors of cunty human or social services agencies (See C.R.S. §19-3.3-11(3)(a)(VII)(C)	Anna Cole	Colorado Human Services Directors Association
A foster parent certified by a county department of human or social services (See C.R.S. §19-3.3-11(3)(a)(VII)(D)	Chelsea Hill	Foster Parent with Lived Experience
A foster parent certified by a county department of human or social services (See C.R.S. §19-3.3-11(3)(a)(VII)(D)	Jana Zinser	Foster Parent with Lived Experience
A kinship provider certified by a county department of human services (See C.R.S. §19-3.3-11(3)(a)(VII)(E)	Jenelle Goodrich	Kinship Provider

A kinship provider certified by a county department of human services (See C.R.S. §19-3.3-11(3)(a)(VII)(E)	Vacant	
A representative of a statewide association that represents child placement agencies (See C.R.S. §19-3.3-11(3)(a)(VII)(F)	Jenna Coleman	Executive Director, Specialized Alternatives for Families and Youth
A repetitive of a statewide association of family and children's agencies (See C.R.S. §19-3.3-11(3)(a)(VII)(G)	Becky Miller Updike	Executive Director, Colorado Association of Family & Children's Agencies (CAFCA)
A representative of an out-of-home placement provider that serves children in the child welfare system (See C.R.S. §19-3.3-11(3)(a)(VII)(H)	Brandon Miller	Executive Director, Southern Peaks Regional Treatment Center
A young adult who is under twenty -two years of age who has experienced residential care placement (See C.R.S. §19-3.3-11(3)(a)(VII)(I)	Vacant	
A parent or family member of a child who has run away from out-of-home placement (See C.R.S. §19-3.3-11(3)(a)(VII)(J)	Kevin Lash	Parent
A parent or family member of a child who has run away from out-of-home placement (See C.R.S. §19-3.3-11(3)(a)(VII)(J)	Elizabeth Montoya	Parent
A representative of a nonprofit organization that serves children or youth who have run	Norma Aguilar-Dave	Director of Adolescent Services, Savio House

away from out-of-home placement (See C.R.S. §19-3.3-11(3)(a)(VII)(K)		
A representative of the Chief's of Police, recommended by the president of a statewide organization representing the Chiefs of Police (See C.R.S. §19-3.3-11(3)(a)(VII)(L)	Dave Hayes	Colorado Association of Chiefs of Police
A representative of police officers from a rural jurisdiction (See C.R.S. §19-3.3-11(3)(a)(VII)(M)	Tim Bell	Commander, Canyon City Police Department
A representative of police officers from an urban jurisdiction (See C.R.S. §19-3.3-11(3)(a)(VII)(M)	Brian Cotter	Sergeant, Denver Police Department

APPENDIX C

Timothy Montoya Task Force Membership Charter

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

Introduction

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

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

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

Mission

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

Charge

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

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

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

Definitions (see other sections for more detailed descriptions):

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

Task Force Outcomes

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

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

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

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

Ground Rules

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

Media Protocols

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

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

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

APPENDIX D

University of Denver Report

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

REPORT HIGHLIGHTS:

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

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

Abstract

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

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Acknowledgements

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

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

Data Sources

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

Suggested Citation

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

Note on Language Regarding "Runaway"

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

Introduction

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

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

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

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

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

Project Rationale and Description

Project Rationale

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

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

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

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

Project Description

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

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

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

Methods

Purpose of Qualitative Research Perspectives

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

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

Sample

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

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

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

Focus Group Protocol

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

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

Key Findings

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

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

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

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

Focus group participants indicated three conditions that led youth to run from their out-of-home placement.

- **Running from the placement due to dysregulation from triggering events, disconnection from staff, and responses to previous trauma.**
- **Running to connectedness and familiarity.**
- **Running due to typical adolescent behavior.**

Conditions that Led to a Run: Running *From*

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

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

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

Triggering Events

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

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

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

A Disconnection with Staff

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

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

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

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

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

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

Responses to Previous Trauma

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conditions that Led to a Run: Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Opportunities for Prevention: Consequences and Connectedness

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

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

Fear of Consequences

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

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

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

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

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

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

"We'll have a kid that has had a really bad family therapy session or a bad phone call or something and gets really upset. And so, that fight or flight kicks in and their go to is to flee in many situations, but our staff really work hard to try and intervene and just, you know, get their brain and their body back to a place where the adrenaline and the cortisol isn't just pulsing through them. Often times when the staff are able to get their body just regulated, those compulsive urges to just take are just kind of gone. Then we can further process. But I've seen many, many situations where as soon as we get the kids body back to a state of regulation that impulsive urge really just – it's dissipated."

"I actually just had this happen with a kiddo this past weekend where he wanted to leave after a bad phone call with dad and leaned on myself because I was his therapist to really try and encourage him – or pull him out of that headspace of wanting to run. And a lot of times it's a battle within themselves on what they're going to do. I've seen it a lot where they try and lean on kind of us as their safe space to support them."

Connectedness with Provider Staff

As demonstrated above when a provider successfully talked a youth out of a run, connectedness with a provider emerged as a strong running prevention strategy. Youth described staying where they feel safe, seen, heard, and valued. Youth indicated that taking a short walk with a staff member is all they needed to calm down, process, and return to their program. However, as discussed previously, staff shortages significantly limit providers' ability to establish and maintain the kinds of connections with youth that allow staff to anticipate when youth are heading toward dysregulation and a potential run.

"I just want to point out like this lovely staff on the left here. I look forward to her smile every single morning. Like even if she's [the staff] going through something, she will always come into work with a smile. I hardly ever hear, "I'm proud of you from any of my family members." But you go to her and she's like, "Great job. Like I'm proud of you." She will not point out your flaws, but she will always compliment you on things that you're doing successfully. If I'm ever sad, I just want to see her smile. And it's just so goofy, and silly, and I love it."

"It's connection with people, when kids have good connection and you're able to pull that person into maybe the situation that's brewing, that may help make that child be able to process differently. It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day."

"We're always using and putting ourselves in positions to try and intervene in a non-physical way first at the lowest level, making sure that we do have incentives in place and goals, and distractions and everything possible to prevent them, engaging them with activities. I know we now have our rec team and our rec therapists. We have the kids riding bikes around the track and getting outside, and doing things to try and prevent them from even wanting to run, but I'm going to be honest in the

> fact that it's dangerous for a lot of these kids that we're working with to get out of the facility and out of staff supervision because they're on a one-to-one supervision throughout their time."

Connectedness with Peers

Peer connectedness was also reported as a means of prevention. Youth described leaning on trusted peers to talk them through issues like anger, frustration, and disappointment and felt calmer as a result. Youth also described talking to each other and rationalizing about potential consequences for running.

> "I guess me personally, I've helped out a couple friends that were in that head space of running away. But all I normally do is just sit there and talk to them and see what's going on, and then, if something's wrong and they're really just sitting there and just – I guess the best way to describe it is just sitting there and reflecting on it and just letting it bring them down in that head space. I just try to talk them out of it."

> "I've talked to people—it would be beneficial to learn how to understand the fact that whether or not it's happening instantly, something good is going to happen, whether that be something simple, like not having the opportunity to go on passes and then having the opportunity to go on passes, or discharging and having—still having restrictions at your house, and then being able to do more stuff as time goes on because you worked for it and you've earned it. So, it doesn't matter if it's instant or not; it's something that's going to happen"

Conclusion

Connectedness matters for children and youth in out-of-home placement. Connection between caregivers and youth is essential for the mental well-being for all youth, but especially for youth who have experienced trauma. Youth run as a means of getting their needs met, and at times this can result in tragedy. Young people do not always have the developmental capacity to fully anticipate or comprehend the consequences of their actions. However, connectedness is a protective factor that can serve as run prevention, intervention, and aftercare. Unfortunately, when connection is made more difficult by a workforce shortage, that puts kids at higher risk of becoming dysregulated and running.

In order to enable connectedness, treatment facilities need to be adequately staffed and have the time and support they need to make meaningful connections with youth. Providers also highlighted the need to clearly define terms in C.R.S. § 26-20-102(6) considering the variety of circumstances under which running incidents occur. Providers indicated the need to work with state agencies and law enforcement to define the word "imminent" and come up with solutions to help providers to have more autonomy in running prevention efforts.

Appendix A: Semi-Structured Interview Protocols for Youth and Providers

Youth Questions

As we talked about in the consent form, I am here today to listen to your thoughts about why young people run from out-of-home placements (like treatment facilities or foster homes). The people listening to what you have to say today want to understand more about why people run so they can make things better for you and other people who live in an out-of-home placement. I will ask you some questions about experiences you, or someone you know, has had with running. There are no right or wrong answers and you can share anything that feels important to you.

1. Why do you think young people run from out-of-home placements?
2. What was happening for you, or someone you know, right before running?
3. Do you know of someone who has thought about running but decided not to run? Tell us more about what you think it was like for them.
4. Have you ever felt like you wanted to run from an out-of-home placement? If so, did you run? Why or why not?
5. Has anyone who has stopped you, or someone you know, from running? What was that experience like?
6. How would you feel about yourself or a friend being restrained by a staff member to stop you from leaving an out-of-home placement?
7. Was there something a staff member did that made you want to run away? Was there something a staff member did that made you want to stay/not run away?
8. What do you think would stop someone who was thinking about running from running? from thinking about running?
9. Where are some of the places young people go when they run? Why do you think they go there?
10. What happens to people after they come back to the out-of-home placement after running? How are they treated? Is there anyone who helps them?
11. Is there anything I did not ask that you think I should know about people who run from out-of-home placements?

Provider Questions

The following questions were asked of provider focus group members after the informed consent and demographic questionnaires were completed.

1. Why do you think young people run from out-of-home placements?
2. Tell me about some things that are happening for young people right before a running incident?
3. How often do children you work with talk about running from their out-of-home placement?
4. Can you think about a time where a young person thought about running but did not? What was that experience like, and what do you think prevented them from running?

5. What do you think about physically restraining a young person to prevent them from running?
6. What do you think would stop someone in your placement, or children in general, someone from thinking about running?
7. Where are some of the places young people go when they run? Why do you think they go there?
8. What happens to young people in your placement when they return after a running incident? How are they treated? What supports are provided to the young person and their family? What conversations do you have with the young person regarding why they ran? What plans are discussed with the young person regarding preventing future runs or ensuring safety of the young person while on the run.
9. What, if any, have your experiences been like with law enforcement when young people run from their out-of-home placement?
10. What do you think needs to happen to prevent someone from running from the out-of-home placement where you work?
11. Is there anything else I did not ask that you think is important to share?

Appendix B: Additional Focus Group Participant Quotes by Topic

Topic I: What conditions led to running from an out-of-home placement?

Conditions that Led to a Run: Running *From*

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

Triggering Events

"Often in our facility, it happens when a kid gets bad news, or gets told no to something that they're really wanting. We see kids run for numerous reasons, whether it be getting caught for doing something they weren't supposed to be doing, being held accountable, or even a phone call with a future placement that doesn't go well. Often, they're super dysregulated and not necessarily thinking about their future; it's in that moment, what's going on."

"The majority of any clients who have actually run, and it's because they've gotten bad news from their team or they've got extension or it's like it's now side factor, they got bad news and we had nothing to do with it."

"I definitely think that that's a pretty big factor. But I also think, since that is their team, sometimes their families call and tell them. We had a kiddo a few weeks ago that mom called and said a Dependency and Neglect case was open on her. And we didn't know that, and the kid was upset for a long time and finally it came out. Even just their families. But I do think the teams often tell them information that would be good for us to know in advance."

"It's kind of an uphill battle for us at times to get it in place. You try to keep those kids, you know, where they're at. But I think their trying to really be with family or be around friends, that kind of stuff, is a pretty common reason as well."

"I think there are times that we know in advance as well and are able to provide support, but I do think that it's not just their teams. It's also families. A lot of times they're with us because their families are unhealthy and have unhealthy patterns, and that comes out in phone calls, and they share stuff that they shouldn't share or we should know before they share, and that doesn't always happen unfortunately."

"We saw a lot of times just the uncertainty that kids have around what they're being told by their teams because they couldn't comprehend what treatment was and what that looked like for them as far as how they were going to complete something, as much as we would try to break it down and have them understand. Objectives from the different players on their teams, that uncertainty and disappointment."

"Some kids will have a bad phone call, so they're running from that even though that physically isn't here but it feels like it is."

Disconnection with Staff

"There is some staff that make it to where the youth that are causing the issue are their one priority. Like if there's a youth screaming, yelling, whatever, they said, 'Oh, wait, we're gonna have to wait to process because this is –.' It's just, it's frustrating because we don't have enough staff on the floor to process, or if we don't communicate how we feel, we get in trouble for it. It's, like, some of us don't even know how to communicate how we feel. It's hard to just tell staff how we feel, especially when it's like we don't feel that most staff listen."

"I just graduated high school here. I just, I'm trying to move forward, and I can't do that when everyone else on the unit needs something else. There's probably I think 13 or 14 people on our unit, and like day-to-day, staff when we have time for to get to three or four to be able to talk to them about what they're going through that day."

"I've never I've never AWOL-ed here. I've had the thoughts of going to AWOL, or walking out. I don't know. Maybe like the lack of consistency, or it feels like we're not being listened to sometimes."

"The de-escalation tactics are either, hey, let's sit down and talk about it. If you can't talk about being unsafe, we're just going to restrain you. It's like I either choose to be restrained, or I choose to run out of the gates because I'm so escalated, and nobody's gonna let me breathe. It feels very caged and trapped right before I have to feel like I need to walk. It's happens more often than not."

Responses to Previous Trauma

"You could have told by my face. You could have told by my body language, that I was not okay. And they just like ignored it, and pushed it off, like, oh, we're talking about the unit having bad hygiene, or bullying. It was one of those groups, and I just need to leave. I'm going to flip. And I have like talked prior to this to a staff, and said, I just need to go on a walk to get my adrenaline out. Because it's like, you know, when you have ADHD, and then you have like bad anger, like when you get to the point where, like you're mad."

"I feel like sometimes when people went AWOL, they, they feel like they can run from their fears and their problems, and I know for a fact, that's not true. You can't run from your problems. You can't run from your traumas, and from your fears. What happens before people go AWOL is that either they get so worked up, that they just can't handle it anymore, then they just walk out. It gets to the point where it builds up so much, that you can really walk out to help it feel better."

"Some youth self-harm because they just want to feel better. They want help. And so staff don't get that, they'll just like quickly give you an assignment or something like that. Yeah, they have a self-harm assignment, which I think is just – it doesn't help, whatsoever. The only kind of recognition I get is when I walk."

"A lot of times, these kids try to run away to harm themselves, as well. There are a lot of threats like, 'I'm going to run in front of traffic,' or 'I'm going to kill myself,' right before they run out the gate."

"Sometimes this place, or wherever they are, is the safest place that they have been. And I think that that scares a lot of our youth. And so, they want to run back to the place that they feel comfortable with and, like someone else mentioned, run back to their friends or and things like that. So, I think

feeling safe and secure in a place really scares them, and so, they want to go back to what they're feeling comfortable with."

"I think sometimes they're just self-sabotaging, too, like they know that they have a safe place in here and they're cared for, but then they get scared that they'll have to leave eventually so they want to sabotage themselves. They want to run away and act out to make sure they don't leave anytime soon."

"I feel like some could just be scared to come into a facility like this one. Not that there's necessarily anything to be scared of but some people might just be scared and want something different and run."

"It's just really across the board because sometimes kids can take off and they seem calm and regulated and seem like things are fine. Other times they'll take off as a result of some sort of trigger that occurred and they get really emotional and upset."

Conditions that Led to a Run: Running *To*

Connectedness and Familiarity

"There was a time where I was planning an AWOL, where I was going to find somebody's phone, to run back to a home that I was previously at. I was going to call. I was gonna, 'Hey, come pick me up. I want to come home.' It was never my plan to like go to Walmart or anything. I was just trying to find a cell phone so I can get a ride to my house. I wanted to go home. I wanted to see people that haven't seen in a while, and I'm just like, 'I miss you guys, pick me up.'"

"My sister, for instance, she's ran to, I guess, her friend's house just so it's away from family, and she can just sit there and think. Or she just goes somewhere where it's peace and quiet."

"Some kids can go on passes and just stay and not come back. It doesn't necessarily have to be like they go on the pass and then they run away. It can just be they go on the pass with their family and then they just stay with their family and don't come back."

"They [peers] sometimes just want to go home. I know a bus place not that far from here like in a town over there. One night me and [another youth] went AWOL. But then the cops came and I had to say I'd give up."

"We broke into a house. Oh, and when we have the opportunity to drink, and we have the opportunity to smoke, we're gonna do it. There was like a whole tray of alcohol sitting inside so I broke in and I stole the alcohol. I stole the iPad. I stole shoes. And we went out, and we got drunk. That's how I go when I go AWOL."

"I need to leave this place. I need to get back home."

"There's running from something and running to something…friends, drugs, the families, probably in that order…"

"I think it's discussed most within the population of like the trafficking youth. I think a big reason for that is, these traffickers know substances to keep those kids under control. Right? They know if the kid would go into placement or even run away from them that after a few days they start showing like withdrawal symptoms and they're going to run right back. I think the substance abuse stuff, it causes a lot of those conversations too. And those are the kids that we see having those conversations the most in our care, are the traffic youth."

"What they know is coping, right? They know to go and use substances, they know to go and find a place where they can do the things that make them feel good in the immediate."

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

"I notice that every time I've seen someone run from a home or a facility they've always went to a store for some reason. I don't know why. Maybe it's that feeling of being free and being around other people that have that same opportunity of just being free and doing their own thing."

"They [peers] usually go down the street to the skate park, somewhere to hang out with other people."

Youth Who do not Understand Consequences of Typical Adolescent Behavior or Intentional Running

"Some people end up getting chased by animals, apparently fighting bears. Laying on the side of a foothill for the night. Going to Walmart, and dyeing their hair in the Walmart bathroom. Sprinkle in some hanging out with some random homeless people under the bridge. Some people get robbed by hobos. And, you know, and get drunk, but they're still drunk two days later."

"I think a lot of people don't know where to go, but like some people go towards that cactus field out there. It was like my first place I went."

"When I went with [another youth] one time he asked people from vehicles from a skating rink like in the parking lot who came out of their vehicles, and he was sitting on the bench crying to make it look like he was injured or something. He kept on asking people for favors from like cash."

"I go most when I AWOL is – the first time, I was just out in the wilderness. The second time – well, the few first times, I was out in the wilderness. Second time, I hid in a porta-potty."

"Some people talk to random people and be like, 'I used to be like you.'"

Youth Rights and Justice

"I've AWOL-ed a lot of times while I've been here. Personally, the things that triggered me to AWOL, sometimes it's phone calls because you only get a certain amount of people o++n your call list. And the only one I can call is my mom. And it's hard sometimes because when they refuse you phone calls, it makes you – it just makes me feel like they don't care. So you feel like you need to walk out, or AWOL. But I AWOL because, usually, it's just me because I'm pissed."

"I'm pissed, and staff will process with me about it. I felt like, because when I first got here, the reason I AWOL-ed was because I wouldn't get my personals. I did not feel comfortable in the clothes that were provided here. They refused my clothes because they said that it was a privilege to have

my clothes because if my behavior isn't on point, I don't get my clothes. I was, I was just kind of angry about that."

"I guess being locked down, not being able to have freedom."

Topic II: What efforts were made to locate a child or youth after a running incident?

Contacting Law Enforcement after a Run

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

"Sometimes the police, they look at the kiddos file and their diagnosis and their history and make a really quick decision on whether the kid is high-risk or not and don't always take into account the fact that we worked hours and hours with these kids. We know these kids. We know their families. We know the background. It can be very difficult and challenging too, when you're sitting here telling a police officer like, 'This kid is high-risk. We need to – you know, you need to be looking for him, and they're like, 'Yeah, if he doesn't show up in a few hours we'll send someone out or we'll let everyone know to kind of keep an eye out.' But you know when they're telling you they're not actively looking for a kid."

Staff concern About Youth Who Run

"We saw a lot of walkaways, or running away when they would get dysregulated. We were out in the middle of nowhere, and so they would become dysregulated. Maybe they had a bad phone call, a bad visit from their family and/or client manager, caseworker, GALs [guardians ad litem], and we would just see them do that walkaway thing. Towards the end, we had a perimeter that we could follow them and try, you know, engage them to come back. With their dysregulation and their age, it did become a safety issue for them."

"I think for us, one of the things that we rely on is planned interventions. If we know that kids have a history of that unsafe behavior or running and they're looking for that freedom, we can place kids on AWOL precautions where we engage in extra supervision with these kids. We put them in clothing that is easily identifiable so if they run, we know exactly what they're wearing, so those planned interventions make a big thing. The second thing is programming, making sure that the kids are engaged in things throughout the day, and that less time for idle hands, the less time for them to really kind of make decisions for themselves, to make sure that they don't have the time to think about, 'Hey, I want to AWOL,' and then go."

Trafficking

"I used to do transportation, that I've had to go all the way to [another state] to pick up kids. I went to other states to pick up kids that went AWOL, and it's really scary to me to know, especially that that truck stop is going to be there, that there's going to be a hotel there; what are these kids going to be doing at some point in time? It is really terrifying to me."

"With our population right now, we have numerous youth that are on clinical precautions and have been for months, that if they get a hold of the wrong type of lid or the wrong piece of plastic off of a container, they've got lacerations and cuts all over their bodies. We're working with kids right now that are so out to self-harm that to allow those kids into society without having someone to intervene is scary. For us, it does determine that that is an imminent danger for themselves. Then, we also are working with a youth that we're learning over time is in imminent danger because if she gets out of the facility, she runs to a house and goes in a house—she is developmentally delayed—and then she is assaulting people with anything she finds on the road or going in front of traffic just because."

"They go to [a store] down here. They ask for rides, they ask people to buy them whatever they need. They just steal it, they'll shoplift, they'll just go get clothes and put them on to get out of the clothes they're wearing."

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

"They also go to the hotel. We've had kids that have gone to the hotel and ended up in situations that we wouldn't want them to be in again, just based on getting in vehicles and then just going there because that's what they know, and that is their survival skills right there."
"When you talk about it's dangerous to do, because they don't know what they are putting out there or what person may not find them as intriguing as they find themselves. I was surprised how many people would pick these kids up walking down a country road, or if they went the other way, it was a housing development with a golf course, as well – so there was shelter, they would find the different little shelters. Also, because of much more open access to phones and different abilities to communicate, if you're doing work at school and you know how to hack into Facebook and all those different things that you think you have firewalls against, communicating with the outside world, we definitely have kids picked up often in different locations from their friends or family, or acquaintances."

Topic III: What services were provided to the child or youth after a run?

"We also conduct a search and shower, which is basically where they have to turn in all of their clothing that they were off campus with so we can search it. They then have to shower with lice shampoo, because we have had youth who have gone off campus who hang out with some individuals who were homeless and then contracted lice and different things, and then we provide them with facility clothing. Then, there is a big debriefing process, a processing that has to happen to discuss the behaviors and the prior events that caused that behavior, because if we don't know what caused it, we can't help make a safety plan to negate those things."

"When possible – especially if the police brought the client back or if they came back just checking in with them. If they're able to process before going back into the milieu, then great. If they're not, we still at least need to be like, 'Are you going to be able to be safe in the milieu?' Just at least, you know, making sure they're not in any sort of headspace that's going to negatively affect the of the milieu before we bring them back there."

"It's not that we even want them [law enforcement] to be the ones intervening. Often, I'm noticing their techniques and theirs is very compliance-based, and they don't intervene in a way that we would as a trauma-informed facility, so it's not a positive thing whenever we have [law enforcement] being the ones bringing back our kids, or in physical management with our kids. I don't think I've had a time where I've felt very positive or comfortable with the way they intervene, which is not to say that they're doing anything wrong. It's just the way they're trained versus the way we are trained, which is why we try and keep our kids as close to home as possible so that we can prevent as many of these hands-on and spit-masks, and we don't slam kids, but if a kid gets out, like they did this week, and goes to swing at a cop, you're going to get slammed to the ground, and that does happen."

"They don't treat you like, 'Hey, you ran because you had an issue.' It's more like, 'You ran because you're a bad kid. Or you ran away because you needed attention or whatever.' It's not, 'You ran away. What's wrong? Why did you run?' It's never, 'What happened?' It's, 'These are the consequences now.' Consequence after consequence after consequence, to the point where I got put into seclusion. Like it was bad when I got back. I feel like I wasn't treated like a human. I felt like I was treated like an animal, or like a number. I was a stamp, you know, just put in a room to calm down."

"I guess the environment, getting with – getting you sick. If you stay out too long and it's a cold night, you'll get sick. They have illnesses that can happen. Basically, though, it's a natural consequence where you go – you run and you get picked up and go to jail. That's a natural consequence because you did it to yourself where you're getting sick."

"If you're frequented AWOL, you're frequently AWOL, you're like, 'It's not really a big deal. Just come back and get back on the program.' But if you rarely go AWOL people will ask like, 'You need help with anything? Do you need anything?'"

"When I came back from AWOLing, I didn't really get treated any differently. Everybody hated my, like, staff-wise, hated my guts, because I was already acting a fool before that. I already had a whole reputation. I was still treated absolutely horrid. Then I got changed to a different unit, and it was really great there. Anyway, but my thing is, like, staff-wise, staff will do whatever."

Topic IV: What programmatic and systemic barriers make it difficult to prevent a run from occurring?

Defining Imminent Danger

"Some of the neighborhoods that, you know, houses are located in our – we're in [a city] and the kid goes to run and we're not in the greatest neighborhoods, where does that leave us? We have gang kids that we've had where someone – you know, that's affiliated with the gang that they're in… has been killed. And this kid it has talked about paybacks and things like that. So to me that would mean he's a danger to others to others. Right? In that situation. I just think asking some questions about

where that risk lies and where it crosses over to imminent risk is some of the questions that I think need to be asked. At what point does this become an imminent risk to yourself or others?"

"There are competing rights. Kids have the right to leave the facility. I think for a lot of us we also have the view that kids have a right to safety. They have a right to be protected from being trafficked. They have a right to be protected from overdose. They have a right to be protected from being hit by a car on the side of this highway. Like, they are children. We are adults. They need to be protected by us."

"Sometimes, knowing, seeing a kid that's completely out of control, that is completely chaotic, that's saying they're going to run off campus and get hit by a car, at that point, sometimes physical intervention is absolutely needed, because when they can't manage their safety, we will have to intervene and do it for them. Physical intervention, at the end of the day, is an asset to us, to be able to maintain that safety at all points."

"Clearly, this has evolved over the last 20 years that I've been involved. We used to physically intervene with kids that were leaving, and that changed through licensing regulation, or interpretation of the licensing reg, is what I would say, because it says imminent danger and how that is interpreted, I think, is very different with circumstances and the kids that you're working with. I think, over the years, that became a really difficult thing to put into practice. You know, [another provider] just talked about they've added a cost by having to contract with the local police department."

"We end up waiting and waiting for that moment where we could, I guess, prove or justify lethality or imminent danger, and we end up putting ourselves and our kids, our staff and our kids in a more unsafe situation by doing that because the waiting is just as dangerous as intervening. Not doing something can often be worse than doing something, so trying to wait around until we're not going to get in trouble before we stop them, even though we know we should be stopping them, and then we end up in a worse situation is not really the wisest intervention in my opinion."

Staff Shortage

"I've been asking to talk to some staff here for days now, and the only time they talk to me when I was crying yesterday when I found out my brother, I was gonna lose my brother."

"It's like staff's fault 80, 90 percent of the time, but on other hand, a lot of it isn't because of staff. It's more because there's staff that obviously are mistreating, you know, saying not okay things, all that kind of stuff, but there also are a lot of staff that will try to get your priorities met, but are incapable because there's a staff shortage, and there's only so many of them, and a lot of us."

"It does get really hard when like those people [peers] that are the problems ask to process the staff that you've been waiting to process for days, and they have been trying to get to you. That makes me really upset. Because like I've been waiting for – we're five days now. And there was another youth that asked to process, and then got processed with, which is got really frustrating to me."

"It really talks to that caring environment, full staff, and safe environment physically, and all those different things that, unfortunately, are not always available, and the intent to ensure that we have more than one person that these young people can connect with, but I think that speaks to a bigger issue. I think that speaks to a funding issue. I think that speaks to an issue of for us to get really good people in the door, and caring and intrinsically there, is no different than the schoolteacher world, right? We aren't able to pay people what they're worth to do this type of work, and it's getting harder and harder every day."

"Unfortunately, we ebb and flow with staffing patterns in the sense of I feel like we're always green on the direct care staff, but, once again, it goes back to the people that are super good with kids tend to move away from kids. They become administrators and they become case managers, and our direct care staff are the ones that are with the kids all the time, and we definitely see a less experienced person doing the day-to-day, the hard work on the front lines."

Law Enforcement

"I think that there's just not a good understanding or knowledge of what we do and what our policies are and what we are allowed to do and what we are not allowed to do as well as there are some misconceptions we have about them and what they are able to do and incapable. A lot of it is a communication issue [with law enforcement] and that we are all working in a really sensitive field and there's a lot of pressure put on everyone from every direction who are all nervous about making the wrong decision."

Reporting Requirements to CDHS

"Even though [the child] did some transgression, something happened. Again, on youth that have histories of delinquency have all of a sudden been more empowered than they were before all that took place. And that's where we all struggled, is, you know, we love kids. We want to work with kids. We want to see them succeed. We want to see them go home and live and live happily ever after. And we work really hard to do that. And then to have the default be you're doing something wrong when you're performing your duty is just backwards. It's completely – makes no sense."

"The thing that we are really missing is the availability to make our own decision about how we intervene. We're being forced to make a decision based on compliance reasons, and that's just being honest about our situation because we typically – if feel like the scales have an overbalance on this issue of not intervening for compliance-based reasons, and I don't think we should do that. However, I don't think that should be prioritized over the safety risks of the youth leaving in all these intricate, judgmental things that happen after the fact of why you did something, or whatever. My personal opinion is that if we were allowed to monitor our own compliance-based interventions and deal with that, because we don't want to do that, that's not our mode of interacting with kids or our program setup, but everybody is with a magnifying glass judging if we're doing that or not. If we were allowed to monitor that and we were allowed to intervene when we feel like it's an unsafe situation for a kid, we would stop kids from leaving the campus, and we would handle it in our way that we are trained to handle things on the grounds."

Topic V: Opportunities for Prevention: Consequences and Connectedness

Fear of Consequences

"The consequences, because like – You'd lose your privilege for the day, three days. Lose being able to go places. You got all your stuff taken out of your room."

"When I see people who are going AWOL I remind myself I want to go home. I also want to see my family. So I just look on the bright side and don't AWOL."

"If you go AWOL for two hours, right, so two hours you're just out walking around, but like that doesn't add up to three days. Like why would you go AWOL for two hours just to have to lose everything for three days?"

Connectedness to Providers

"The staff will talk me out of it."

"Last night like a staff stopped one of the kids from going AWOL. The staff said, 'No, you're not going to go out that door.'"

"I would say the biggest thing that helped our kids stay put was when they were connected to enough staff that they felt cared about."

"I think we see this very frequently. I think we probably see this more than the kids talking about it and then actually running. Our staff are really trained in de-escalation and processing and co-regulation. And they're able to verbally tell us if they're wanting to run and verbally tell us why, then doing those things to help co-regulate and bring the kid back down has been a huge help."

"I would also say that when a young person tells you they're going to run away, when they're thinking about running away they're looking for – that's a lifeline. They're asking for help. The people that run away typically don't tell you. You might see warning signs but there won't be an outward…yeah. My experience is that when a young person says, 'I'm really thinking about running away,' he's looking for permission to stay and perhaps different support, better support, in the program that he is in or she's in."

"I agree with that. I've seen that a lot too. Like, I've had a client that would literally just say, "I'm going to run," and he'll get down to the end of the hallway but then he'll turn around and make sure staff was – but he never got out of the building. He just wanted to make sure we were following him. So I do feel like there's a lot of just following him around, processing, trying to process within an encouraging them to make the right decisions. And whether that's in their best interest."

Appendix C: Coding Strategy

Phenomenological methodology involves exploring lived experiences of people as experts in their own lives. This type of methodology involves taking a holistic view of the data to understand the phenomenon being studied, in this case lived experiences with running incidents. In this program evaluation process, the PI captured the essence of what it was like to experience a run personally, as a peer who runs, or from the perspective of the service provider. The coding process in this research approach involves the following methods: epoche, phenomenological reduction, horizontalization, imaginative variation, and synthesis of meanings and essence.[1] Each of the following steps occur in order, as the steps are intended to build upon one another, and one cannot happen before the previous step is achieved.[32]

Epoche

This first step means to refrain from holding dogmatic views of the phenomenon being studied. In order to accomplish this step, the PI and external coders evaluated any previously held biases, understandings, or judgements regarding running incidents and behaviors.

Phenomenological Reduction

The phenomenological reduction process involves viewing all participant statements in an open way and aiming to recognize any bias that may hinder the evaluators in fully understanding the participant experience. Methods used to address this were evaluator journals, listening to recorded interviews multiple times, and carefully reviewing interview transcripts.

Horizontalization

This process involves giving each participants' statements equal importance by setting aside evaluator bias or opinion. To accomplish this, the evaluator reviewed transcripts independently and worked with external coders to evaluate accuracy.

Imaginative Variation

Each external coders read transcripts according to the codebook. The PI carefully considered the possible underlying causes or influences that may have impacted participants in their experiences with running from out-of-home placements. The PI and external coders selected salient participant statements to represent the textural essence of the phenomenon that was studied.

Synthesis of Meanings and Essences

This final step in phenomenology is intended to synthesize the meaning and essence through a rich description of the phenomenon. This step is represented in the results section by integrating participant quotes.

Trustworthiness

One evaluator conducted the interviews and evaluated the transcripts. In order to reduce bias, the PI consulted with two qualitative research coders to reduce bias and subjectivity in the data analysis process.[33] Additionally, the PI used five criteria to address trustworthiness: credibility, transferability, dependability, confirmability, and authenticity.[34]

Credibility

Credibility refers to the importance of viewing each participant as an expert in their own life and experiences.[35]

Transferability

Transferability is the extent to which the results of can be applied in other contexts.[36, 37] The quality of transferability depends on the evaluator's ability to describe the evaluation process and findings for the reader to determine its applicability to their context.[38] In this report, findings were represented with direct quotes that support the findings.

Dependability

In qualitative research and evaluation, the concept of dependability is related to whether the data collected is stable over time.[39, 40] This was achieved through documenting all decisions made by the evaluator to the Colorado Action Lab Staff, the Office of Colorado's Child Protection Ombudsman, and the Timothy Montoya Taskforce.

Confirmability

Confirmability refers to ensuring the data and interpretations are accurate. In this project, the findings and interpretations were directly linked to raw data and an audit trail of data.[41, 42]

Authenticity

Authenticity is seen as the ability to represent multiple perspectives in data interpretation.[43, 44] This was accomplished through use of two external coders to review the PI's interpretation of data.

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APPENDIX E

An updated examination of the predictors of running away from foster care in the United States over ten years (2010-2019), Caralin Branscum, M.S., Tara N. Richards, Ph.D., University of Nebraska, January 24, 2022

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

Introduction

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

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

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

Mission

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

Charge

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

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

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

Definitions (see other sections for more detailed descriptions):

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

Task Force Outcomes

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

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

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

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

Ground Rules

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

Media Protocols

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

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

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

KEYSTONE POLICY CENTER

INTERIM REPORT

MANDATORY REPORTING TASK FORCE

House Bill 22-1240

Child Protection Ombudsman of Colorado

Facilitated by: Keystone Policy Center

January 1, 2024

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INTRODUCTION AND HISTORY

During 2022, more than 200,000 reports were made to the Colorado Child Abuse and Neglect Hotline.[1] More than half of those reports were made by professionals required to report concerns of abuse and neglect under Colorado's mandatory reporting law. Experts nationally have begun to discuss whether child abuse reporting laws help keep children safe. While there are no studies demonstrating this to be true, there are studies that show mandatory reporting laws can be detrimental to families and communities. Specifically, evidence shows that mandatory reporting disproportionately impacts families of color – initiating contact between child protection services and families who routinely do not present concerns of abuse or neglect.

Colorado was the first state to adopt mandatory reporting laws in 1963. During the 60 years since it was first enacted, the law has been amended at least 31 times. Primarily, those amendments have centered on the addition of specific types of professionals required to report suspected child abuse and neglect. None of those amendments have addressed the infrastructure of the law, nor have they created mechanisms to measure the efficacy of a system that results in hundreds of thousands of reports to child protection services each year. As such, Colorado has entered the national discussion assessing child abuse reporting laws. Nationally, and in Colorado, those conversations have orbited around two primary concerns: (1) The disparate impact of mandatory reporting on families of color, people with disabilities and under-resourced communities; and (2) The overbreadth of a system that routinely absorbs families who do not present concerns of abuse or neglect but could be served by resources outside of child protection. The essential question being discussed is how to balance the safety and well-being of children with the detrimental impact these laws can have.

To address these issues, the Colorado General Assembly established the Mandatory Reporter Task Force (Task Force). The Task Force is charged with not only addressing technical aspects of the law, but considering whether it should be substantially overhauled to address these questions. The Task Force convened on December 7, 2022. Since that date, members have worked to understand and discuss the issues outlined above and create a plan to address them. This report details the Task Force's first year of work, and outlines where the Task Force will head during its second and final year.

Role of the Office of the Colorado Child Protection Ombudsman

Since its inception, the Office of the Colorado Child Ombudsman (CPO) has received dozens of calls from mandatory reporters in Colorado who are unclear regarding the requirements of the state's mandatory reporting law.[2] These inquiries frequently center on the caller's desire to comprehend

[1] See Colorado Department of Human Services media release, "Calls to Colorado Child Abuse and Neglect Hotline remained steady in 2022" January 24, 2023

[2] See C.R.S. §19-3.3-101 to 111

the definition of abuse and neglect, clarify their role as a mandatory reporter and understand the appropriate channels for reporting suspected abuse or neglect. Callers frequently ask the agency:

- What is the definition of physical and sexual abuse? Does it include bullying? Emotional abuse? Educational neglect? Sexting?
- Child abuse is only committed between a parent and their child, right? Or can child abuse be committed by any adult upon a child?
- My agency/employer requires me to report my concerns to my supervisor, is that OK or do I need to call in a report myself?

These calls, in combination with a series of high-profile cases involving allegations of mandatory reporters failing to fulfill their statutory duty, demonstrated the need for an extensive statutory analysis of Colorado's mandatory reporting law. Following that review, the CPO published an issue brief on September 15, 2021, detailing its findings.[3] In summary, that review found that Colorado's mandatory reporting law revealed an inconsistent understanding of the law by mandatory reporters, a fragmented system of trainings and a general lack of support and resources for mandatory reporters to capably do the job asked of them – namely, to report suspected child abuse and neglect. A consistent theme identified by the CPO is that Colorado's mandatory reporting law is needlessly vague in many places and could be enhanced to give mandatory reporters greater support. As such, key findings from the CPO's issue brief include:

- Colorado's mandatory reporting law does not define what it means to "immediately" make a report of suspected child abuse and neglect. This creates inconsistency in the amount of time mandatory reporters wait to call in suspected abuse or neglect.
- Colorado's mandatory reporting law does not state whether policies regarding institutional reporting are permissible.
- Colorado's mandatory reporting law does not state whether a mandatory reporter's duty to report suspected abuse or neglect extends to circumstances beyond their professional capacity.
- Colorado's mandatory reporting law does not create a statewide notification system that informs new mandatory reporters of their obligations to report suspected abuse or neglect.
- Colorado's mandatory reporting law does not require training for mandatory reporters, nor does it have a continuing education requirement for professionals who are routinely working with children and youth and are required to have a license to practice, including doctors and therapists.
- Colorado's mandatory reporting law does not require training regarding implicit bias or the widely acknowledged disparate impact mandatory reporting has on families of color, people with disabilities and under-resourced communities.

Based on these findings, the CPO issued a recommendation to the Colorado General Assembly to amend the law to create a robust infrastructure that supports the state's mandatory reporters.

[3] See Appendix A, CPO Issue Brief, Mandatory Reporters: How Colorado's mandatory reporter law lacks the necessary infrastructure to support those charged with reporting suspected child abuse, September 15, 2021.

History of House Bill 22-1240

Following the publication of the CPO's issue brief – and subsequent media coverage – Colorado Rep. Meg Froelich and Rep. Mary Young called together stakeholders to address the identified issues. Ultimately, Rep. Froelich and Rep. Young introduced House Bill 22-1240, Concerning Enhancing Mandatory Reporting for People Required to Report Child Abuse.[4] Stakeholders and legislators agreed more time and education was needed to discuss these complex issues. As such, the bill created the Mandatory Reporting Task Force, housed within the CPO. The bi-partisan bill passed with overwhelming support.

OVERVIEW OF THE TASK FORCE

Charge and Membership

The Colorado General Assembly established the Mandatory Reporting Task Force to address the efficacy and impacts of the state's current mandatory reporting law. The Task Force is legislatively charged with analyzing the effectiveness of Colorado's mandatory reporting law. This analysis requires the Task Force to look at both the micro and macro level of how the law functions and its impacts on children and families in Colorado. Specifically, the Task Force's analysis must be cognizant of the disproportionate impacts mandatory reporting laws have on families of color, people with disabilities and under-resourced communities.[5] In total, the Task Force must address the following 19 directives:[6]

1. Whether a study should be conducted to determine the effectiveness of mandatory reporting in serving children and families and determine the necessary funding for a study. If the Task Force determines there should be a study, the study must include an analysis on whether enhanced screening techniques for accepting reports may mitigate the disproportionate impact of mandatory reporting on under-resourced communities, communities of color and persons with disabilities.
2. The disproportionate impact of mandatory reporting on under-resourced communities, communities of color and persons with disabilities.
3. Standardized training that addresses implicit bias.
4. Alternative processes and services for families who do not present mandatory reporters with child abuse or neglect concerns but who would benefit from alternative services.
5. Standardized training that addresses the requirements of the law.
6. The definition of "immediately" and how reporting time frames affect mandatory reporters from different professions.
7. Reporting time frames for mandatory reporters who are creating a safety plan for victims of domestic violence, sexual assault or stalking to ensure the safety of the victim and the victim's family members while creating the safety plan.
8. Medical child abuse and the process to report medical child abuse.
9. Whether mandatory reporters should report incidents observed outside of a mandatory reporter's professional capacity.

[4] See Appendix B, House Bill 22-1240
[5] See C.R.S. §19-3-304.2(2)
[6] See C.R.S. §19-3-304.2(7)(a)

10. Whether a mandatory reporter who is employed by, an agent of or a contractor for an attorney who is providing legal representation is exempt from mandatory reporting requirements.
11. Mandatory reporting requirements for mandatory reporters who have knowledge or reasonable cause to know or suspect that a child or youth is the victim of dating violence or sexual assault.
12. A reporting process for two or more mandatory reporters to report child abuse or neglect who have joint knowledge or joint reasonable cause to make a report of child abuse or neglect.
13. Whether the duty to report remains with the mandatory reporter who has reasonable cause to know or suspect that a child has been subjected to child abuse or neglect.
14. Whether institutions that employ mandatory reporters may develop procedures to assist mandatory reporters in fulfilling reporting requirements.
15. Training requirements for people applying for or renewing professional license for a profession that is identified as a profession required to report child abuse or neglect.
16. The personal information of a child that is collected for a report.
17. Standardized training regarding the county department's process to determine which reports meet the threshold for assessment and investigation.
18. The benefits of an electronic reporting platform for the state.
19. A process for inter- and intra-agency communications, confirming receipt of reports and, in some circumstances, sharing the outcome of reports with certain mandatory reporters.

If, at the conclusion of the Task Force's two-year term, members' analysis results in the development of recommendations, those recommendations will be delivered to the Colorado General Assembly no later than January 1, 2025.[7]

The Task Force is comprised of 34 members representing a wide range of professional and personal backgrounds[8]. In addition to five members who have been directly impacted by Colorado's mandatory reporting laws, members represent multiple professional sectors as well, including education, health care, behavioral and mental health care, law enforcement, rural and urban county departments of human services, and child advocacy centers.[9] Legal professionals – including prosecutors, defense attorneys and family law attorneys – are also present on the Task Force. Representatives from multiple state agencies are also present, including the Office of Respondent Parents' Counsel and the Office of the Child's Representative. To solicit applications, the CPO launched a statewide campaign though social media and other communications efforts, as well as working directly with organizations and agencies to encourage candidates to apply. Dozens of applications were submitted, and members were selected based on criteria stated in House Bill 22-1240, as well as professional and lived experience. Throughout the past year, the CPO has worked to fill vacancies and continue to fill positions.

[7] See C.R.S. §19-3-304.2(10)
[8] See C.R.S. §19-3-304.2(3)(a)
[9] See Appendix C, Mandatory Reporting Task Force Membership List

Pursuant to House Bill 22-1240, the Child Protection Ombudsman, Stephanie Villafuerte, serves as chair of the Task Force.[10] The Task Force selected Dr. Kathryn Wells, Executive Director of the Kempe Center, to serve as vice-chair. Both will serve in these roles for the duration of the Task Force.

Facilitation and Support

The CPO contracted with the Keystone Policy Center (Keystone) to facilitate the Task Force's meetings. Keystone is responsible for facilitation and project management as it relates to the activities of the Task Force. Keystone has sub-contracted with Doris Tolliver, Principal at Health Management Associates, who has extensive experience in leading discussions regarding implicit bias in child welfare services nationally and in Colorado. Keystone is responsible for co-designing the process with the CPO office and vice chair and ensuring the Task Force runs smoothly, including promoting full participation of all Task Force members and – when possible – helping the parties resolve their differences and work toward resolving concerns. Working with task force members, Keystone ensures adequate and coordinated stakeholder engagement that will be essential to the Task Force meeting its goals. Keystone worked with Task Force members to develop a working charter to guide the Task Force's work. This charter provides members with guidance regarding the charge of the Task Force, ground rules for engagement and standards for media engagement.[11]

Voting Structure

The Task Force operates under the understanding that its findings and recommendations do not necessitate consensus among its members. Instead, the Task Force aims to ensure an accurate representation of its collective views. While consensus is not the primary goal, the Task Force strives to capture the diversity of opinions and robust discussions by taking polls and making note of individual perspectives to inform its recommendations comprehensively. These discussions and findings are captured in written summaries of each meeting, meeting minutes and the two reports required by law.[12]

Transparency

All meetings are open to the public, welcoming valuable input and insights from attendees. Pursuant to House Bill 22-1240, the CPO works with Keystone to promote each meeting by sending out media advisories and posting information about each meeting on the CPO's website.[13] In addition to inviting members of the public to present during various meetings, information shared during public comment often shapes the topics raised for discussion or inspires ideas to explore further. Consistently, 10 to 25 members of the public attend Task Force meetings, as well as media outlets. Additionally, each meeting is recorded, and those recordings are posted to the CPO's website for anyone to review. Meeting materials, meeting summaries and other materials are also made available on the CPO's website.[14]

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[10] See C.R.S. §19-3-304.2(5)

[11] See Appendix D, Mandatory Reporting Task Force Charter

[12] All meeting minutes and condensed summaries of Task Force meetings are available on the CPO's Mandatory Reporting Task Force webpage.

[13] See C.R.S. §19-3-304.2(6)(b)

[14] Recordings of all task force meetings are posted and available, in full, on the CPO's Mandatory Reporting Task Force webpage.

While House Bill 22-1240 requires the Task Force meet at least every other month, members opted to begin meeting monthly. Additionally, the Task Force will meet multiple times a month during 2024 to ensure members address all 19 directives thoroughly.

To date, the Task Force has met nine times:

- December 7, 2022
- February 1, 2023
- April 5, 2023
- June 7, 2023
- July 19, 2023
- August 2, 2023
- September 20, 2023
- October 4, 2023
- November 8, 2023

FIRST YEAR DISCUSSIONS AND THEMES

Introduction

During the Task Force's first year, CPO staff, with support from Keystone, thoughtfully arranged member panels, presentations by outside experts and member discussions to ensure a comprehensive representation of ideas, perspectives, experiences and knowledge of how Colorado's mandatory reporting law impacts citizens. The syllabus was designed to remain flexible and responsive to the needs of the Task Force in addressing each directive.

In its earliest discussions, members expressed a desire to be bold and develop innovative solutions to the issues identified by the CPO and in House Bill 22-1240. The Task Force approached its first year as a landscape analysis – working to understand how mandatory reporters are currently operating in Colorado, whether reports filed by mandatory reporters promote the safety and well-being of children and, conversely, how reports filed by mandatory reporters can negatively impact children and families.

Intentionally, these broad discussions avoided the technical elements of the law and the development of recommendations during the Task Force's first year. This was done to allow members time to develop a better understanding of how the law impacts children and families and mandatory reporters themselves. The Task Force will use these discussions and understanding, as well as the substantial research and materials provided during the first year, to begin drafting findings and recommendations during its second year. As such, this report does not contain any recommendations.

The Task Force relied on two main directives to guide its discussions during the first year:

1. The disproportionate impact of Colorado's mandatory reporting law on families of color, people with disabilities and under-resourced communities;[15] and
2. Whether the mandatory reporting law is effective at serving families and keeping children and youth safe.[16]

[15] See C.R.S. §19-3-304.2(7)(a)(II)
[16] See C.R.S. §19-3-304.2(7)(a)(I)

During its first year, the Task Force convened for approximately 24 hours of discussion. The Task Force was provided with hundreds of pages of research and outside references. They were also provided – and reviewed – extensive data sets regarding mandatory reports in Colorado and nationally. As a result, the Task Force's discussions were deep and addressed the many layers of a system that has been in place for 60 years. This interim report is intended to serve as a high-level summary of the Task Force's work and capture the recurring themes identified by members. It does not detail every meeting and discussion held. However, materials with this level of detail are available to the public and have been since the Task Force convened in December 2022. ***All meeting materials, agendas, minutes, summaries and recordings may be accessed at the CPO's website.*** These materials will also be referenced and cited throughout this report.

Incorporation and Analysis of Statewide Data

The CPO partnered with Casey Family Programs (Casey). Through this partnership, members were provided with statewide data demonstrating the impacts of mandatory reporting, outcomes of reports made and the disparate impacts of the law on children and families of color. Casey presented data collected from the National Child Abuse and Neglect Data System (NCANS). Summaries of this data are included throughout this report.

Understanding Disparate Impacts of Mandatory Reporting

Doris Tolliver led the Task Force through its February 2023 discussion, providing a comprehensive overview of the disparities within the child welfare system. She underscored the critical importance of comprehending the impact of decision points, particularly mandatory reporting, urging the Task Force to embrace discomfort as an avenue for personal growth and learning. The discussion revealed concerns regarding Colorado's statutory definition of abuse and neglect, highlighting its failure to distinguish between intentional neglect and instances resulting from poverty.

During the meeting, a panel of members and outside experts presented to the Task Force. The panel was comprised of:

- Jerry Milner, Director of the Family Integrity and Justice Works at Public Knowledge and former Associate Commissioner at the Children's Bureau
- Dr. Kathryn Wells, Executive Director of the Kempe Center, Associate Professor, Pediatrics-Child Abuse and Neglect
- Ida Drury, Ph.D. – Assistant Professor, Principal Investigator of the Child Welfare Training System for the Kempe Center
- Crystal Ward Allen, Senior Director, Strategic Consulting, Casey Family Programs

The panel shed light on the imperative need to overhaul the existing mandatory reporting system. Panelists advocated for a shift to a community-centered approach, which entails readily available services and support tailored to families, coupled with an alternative reporting structure designed for reporters identifying family needs that do not meet the threshold for abuse or neglect. The panel reiterated – and discussed existing data – that demonstrates how mandatory reporting disproportionately impacts children and families of color and the lifelong implications of being reported to a child abuse hotline. Stressing the importance of the trauma endured by families and

children who enter the child protection system, the panel prioritized the proactive prevention of neglect.

During April 2023, the Task Force heard from Kelly Fong, Ph.D., an assistant professor of sociology at the University of California, Irvine, regarding her research on the intentions of mandatory reporters and the impact of mandatory reporting on families. Dr. Fong offered a comprehensive analysis of the challenges encountered by mandated reporters, shedding light on the complexities within an environment where families contend with multifaceted issues such as poverty, domestic violence, mental health concerns, substance use and homelessness.[17] She highlighted the constrained timeframes and limited resources faced by mandated reporters, resulting in an overreliance on routine reporting to child protection services as a default solution.[18] For example, she discussed how often mandatory reporters who do not have concerns of abuse or neglect make a report in an attempt to connect the family with needed resources – such as food and housing assistance programs. However, because there is no alternative system for mandatory reporters to call, these calls are placed to a child abuse hotline which often results in a more in-depth intervention.

Dr. Fong underscored how the prevailing culture of routine reporting perpetuates the disproportionate impact of mandatory reporting laws on families of color. The current culture of reporting is supported by the existing framework of training programs and policies that encourage reporters to report any concerns relating to a child, and allowing child protection professionals to determine if abuse or neglect exists. This has resulted in a system that is overburdened by a high number of calls that do not involve abuse and neglect.[19]

In addition to these experts, Casey provided extensive data regarding the disproportionate impact of mandatory reporting. Key figures included:

- Black children are overreported to the child abuse hotline 1.27 times more than their percentage of the Colorado population.
- White children are underreported at about 0.64 in relation to their representation in the state population.
- Nationally, more than half of all Black children experience one child protective services investigation during their lifetime.[20]

Determining the Effectiveness of Mandatory Reporting

With the backdrop provided by early conversations regarding the disparate impact of mandatory reporting and the negative impacts of the system, the Task Force transitioned its focus to determining whether the law is effective at the following:

- Keeping children safe;

[17] See, "Getting Eyes in the Home: Child Protection Services Investigations and State Surveillance of Family Life"; Kelly Fong, American Sociological Review, Vol. 85, Issue 4, pp. 610-38.
[18] See additional research by, Dr. Fong by clicking HERE.
[19] See "We Shouldn't Rely on Child Protective Services to Address Family Adversity," By Kelly Fong, The Imprint, September 20, 2023
[20] See Casey Family Programs Data Presentation, June 6, 2023

- Providing mandatory reporters with sufficient guidance in making reports of suspected child abuse; and
- Ensuring that children and families who do not present concerns of abuse and/or neglect do not enter the child protection system.

Casey provided several data sets and presentations to the Task Force. Those presentations are available on the CPO's website.

Based on discussions held during early 2023, the Task Force found that, generally, there are three reasons mandatory reporters call in suspected abuse and neglect. Those reasons are: (1) Concerns about the immediate and/or ongoing safety and well-being of a child; (2) A desire to connect children and families with resources, but not seeking traditional intervention; and (3) Concerns about legal liability for failing to report concerns of abuse or neglect.

Beginning in April 2023, the Task Force broke its discussions into four categories. Each category represents a group of individuals impacted by mandatory reporting and whether they feel the system is effective. Brief summaries of the discussions and presentations for each category are presented below. Additionally, for each meeting listed below a link to a full recording of the meeting has been provided, as well as a link to a written summary capturing the nuance and multiple perspectives presented.

1. ***People Who are the Subject of Mandatory Reports (April 5, 2023) –*** The Task Force heard from individuals who were subjects of mandatory reports, either as children or parents or both. These individuals shared their experiences with the child protection system and their perspective as to whether the mandatory reporting law improved their circumstances. Panelists stated that the child protection system did provide them needed services, however, it was frustrating that the only way to access those benefits was by entering the system.

    - A recording of the April 5, 2023, meeting may be accessed **HERE**.
    - A summary of the April 5, 2023, meeting may be accessed **HERE**.

2. ***People Who Make Mandatory Reports (June 7, 2023, July 19, 2023, and August 2 2023) –*** The majority of members on the Task Force represent various professions currently listed as mandatory reporters under Colorado's law. The Task Force heard from each of these members, who discussed how the mandatory reporting law impacts various professions and what improvements would assist how those professionals interact with, and serve, children and families.

    - Medical and Mental Health Professionals (June 7, 2023)
        - A recording of this panel may be accessed **HERE**.
        - A summary of this panel may be accessed **HERE**.

    - Provider Professionals (July 19, 2023)
        - A recording of this panel may be accessed **HERE**.
        - A summary of this panel may be accessed **HERE**.

- Education professionals (July 19, 2023)
    - A recording of this panel may be accessed **HERE**.
    - A summary of this panel may be accessed **HERE**.

- Advocacy Professionals (August 2, 2023)
    - A recording of this panel may be accessed **HERE**.
    - A summary of this panel may be accessed **HERE**.

- Legal and Law Enforcement Professionals (August 2, 2023)
    - A recording of this panel may be accessed **HERE**.
    - A summary of this panel may be accessed **HERE**.

3. ***People Who Receive Mandatory Reports (September 20, 2023) –*** The Task Force engaged with a panel comprised of members representing county human services departments, which are charged with receiving and assessing reports from mandatory reporters. Panelists discussed how they engaged with mandatory reporters and where they think practice could be improved to enhance how reports are made and the ultimate outcome of cases.

    - A recording of the September 20, 2023, meeting may be accessed **HERE**.
    - A summary of the September 20, 2023, meeting may be accessed **HERE**.

4. ***People Who Monitor Mandatory Reports (October 4, 2023) –*** The Task Force engaged with a panel comprised of members representing organizations that monitor and assess the mandatory reporting system. Members discussed the broad impacts of the system on children and families and how the current law supports – and hinders – the role of mandatory reporters.

    - A recording of the October 4, 2023, meeting may be accessed **HERE**.
    - A summary of the October 4, 2023, meeting may be accessed **HERE**.

Through these conversations, five themes emerged:

1. Colorado's mandatory reporting law and system for making reports disproportionately impacts families of color, people with disabilities and under-resourced communities. The effects of this disparate impact perpetuate unnecessary contact with child protection services.
2. Colorado's current definition of abuse and neglect is too broad and conflates several circumstances – such as poverty – with child abuse. This effectively requires mandatory reporters to report circumstances that may not involve the safety or well-being of children.
3. Mandatory reporters currently have one mechanism to utilize when they have concerns about children and families – a formal report to the child abuse and neglect hotline. However, many mandatory reporters do not have concerns about physical abuse or neglect and instead attempt to connect children and families with needed resources, such as assistance with food or housing insecurity. By forcing mandatory reporters to report all concerns through the child abuse hotline, the state's mandatory reporting law requires

professionals to engage child protection services with families that do not require their services.

4. Cases that do involve concerns of child safety and well-being may not get adequate attention because the system is overwhelmed by reports. This is perpetuated by a lack of training for mandatory reporters and lack of follow-up with mandatory reporters.
5. Colorado's mandatory reporting law may hinder certain professionals from forming trusted relationships with children and families. This includes physicians and educators who struggle to engage with families, when families are concerned those professionals will be required to report them to a child abuse hotline. Often this results in families avoiding these professionals and associated services and care.

These themes permeated through Task Force discussions and members have repeatedly identified these as priorities for the group to address when it issues recommendations in its final reports.

Additionally, the discussions underscored the dichotomy between prevention and intervention, emphasizing the need to strike a balance and prioritize safety while offering adequate prevention and support measures. Inconsistencies across counties, power imbalances, biases, and uncertainties regarding what constitutes reportable instances were identified as key hurdles. Additionally, the impact of reporting stigma on family bonds and relationships between reporters and families emerged as crucial considerations, alongside concerns about handling cases involving domestic violence. The burden on multiple agencies of overreporting was also highlighted as a pressing issue.

MOVING FORWARD

Grounded in the work it completed during its first year, the Task Force will dedicate its second year to putting pen to paper. Acutely aware of the limited time remaining, the Task Force has identified its priorities for addressing each of the 19 directives provided in law, while also working to tackle the systemic issues identified.

However, to ensure this work is thoughtful and impactful, the Task Force has agreed that it must first address Colorado's current definition of child abuse and neglect. As stated above, the Task Force has routinely identified that Colorado's current definition of abuse and neglect is too broad and conflates several circumstances – such as poverty – with child abuse. Without first addressing the definition of abuse and neglect, the Task Force cannot meaningfully recommend changes to the current mandatory reporting system or law. As such, the Task Force has scheduled additional meetings and will dedicate approximately 11 hours during January and February of 2024 to developing a recommendation to amend the statute.

CPO staff provided the Task Force with an analysis of the standards for reporting abuse and neglect across various states. One notable observation from this analysis is that 16 states have incorporated exclusion requirements or special considerations within their definitions of abuse and neglect. These provisions aim to prevent reports from being solely based on specific categories, indicating a move towards a more nuanced approach. For instance, several states have established criteria stipulating that neglect should not be solely attributed to the socioeconomic status of the caregiver. Factors like the unavailability of relief services or homelessness alone do not automatically qualify as neglect. Moreover, some states emphasize considering cultural differences when evaluating child abuse and neglect reports.

This analysis will support the Task Force's work in formulating a better definition and standards for reporting for Colorado's mandatory reporting laws.

Following the conclusion of this discussion at the end of February 2024, the Task Force will then begin to break into subcommittees to address remaining systemic issues and directives. At a minimum, the subcommittees will discuss possible recommendations regarding the following topics:

- The development of warmlines and alternative reporting methods.
- Addressing vagueness in Colorado's mandatory reporting law, including the definition of "immediately," institutional reporting and policies, the scope of a mandatory reporter's duty and addressing duplicative reports.
- Consideration of possible exemptions for professionals working with legal representation teams and/or victims of domestic violence or sexual violence.
- Development of required training for mandatory reporters and applicable curricula. This will include the development of implicit bias training for mandatory reporters.

CONCLUSION

During the past eleven months, the committed members of the Task Force have dedicated themselves to a meticulous and collaborative process, delving into the intricate landscape of mandatory reporting. Their approach has been defined by a steadfast commitment to inclusivity, nurturing open dialogues and harnessing the diverse wealth of experiences and perspectives within the group.

The Task Force's journey commenced with a deep dive into the complexities of mandatory reporting — assessing its efficacy in serving its intended purpose while comprehending its disproportionate impacts on children and families, including those of color, low-income, and with disabilities. This initial phase drew upon the invaluable experiences and expertise of Task Force members, incorporating insights from national experts and partners. Extensive information was thoroughly examined and discussed among Task Force members, fostering a deep understanding of the subject matter.

From this robust exploration, the Task Force has begun to surface ideas pinpointing areas ripe for change. The initial findings encapsulated in this report form the bedrock for future exploration. In the forthcoming months, we eagerly anticipate refining our recommendations, building upon the collective wisdom and insights gleaned from the Task Force. The ultimate aim is to craft a comprehensive and compassionate approach that better meets the diverse needs of children and families impacted by mandatory reporting laws in Colorado.

Pursuant to C.R.S. §19-3-304.2(9), the Task Force respectfully submits its interim report.

APPENDIX A

CPO Issue Brief

CHILD PROTECTION OMBUDSMAN of COLORADO

September 15, 2021

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ISSUE BRIEF

MANDATORY REPORTERS: How Colorado's mandatory reporter law lacks the necessary infrastructure to support those charged with reporting suspected child abuse.

INTRODUCTION

Olivia Gant was only 7 years old when she died. During her short life, it is alleged that her mother subjected her to five years of countless, unnecessary medical treatments and surgeries which ultimately resulted in Olivia's death in 2017. Her mother has been criminally charged and is pending trial. The allegations are that Olivia was the victim of Factitious Disorder Imposed on Another – a rare psychological disorder in which a caregiver, like Oliva's mother, create symptoms of illness in their children to get attention. Because caregivers often advocate for unnecessary and dangerous treatments, children can be seriously injured and even die.

After Oliva died, questions were raised about how her death could have been prevented. The media and an attorney for the family have raised concerns that Children's Hospital Colorado (CHC), the facility responsible for Olivia's ongoing care, failed to report suspected child abuse as required by law, thereby delaying a child abuse investigation that might have saved her.[1] It is also alleged that the CHC's internal child abuse reporting policy is at odds with Colorado law because it recommends hospital staff members who suspect child abuse to first report their concerns to a lead social worker or the hospital's internal child protection team, before reporting directly to law enforcement, a human service agency or the state's child abuse hotline.[2]

BACKGROUND

Olivia's case raises long-standing questions about whether Colorado's mandatory reporting law is well understood by the thousands of individuals and institutions in Colorado who are required to make child abuse reports and whether the law has been implemented in a way that ensures the state's children are being protected.

Colorado, like many other states in the country, has had a series of high-profile cases, that raise questions about the effectiveness of mandatory reporting laws. To be clear, many of the headline grabbing cases involve adults, in positions of trust – such as school principals, civic and religious leaders and many others – who deliberately chose not to report child abuse in an attempt to preserve an institution's reputation or to protect a colleague from scandal.[2] This brief does not address those cases. Those cases are appropriately addressed by the criminal justice system which is tasked with enforcing penalties for these serious breaches of law.

This brief addresses the thousands of other circumstances where well-meaning citizens – teachers, social workers, nurses, coaches and many others – want to do right by kids but are unclear about how to fulfill their responsibilities to report abuse and neglect.

In the past decade, the Office of Colorado's Child Protection Ombudsman (CPO) has received dozens of calls from mandatory reporters who are unclear on what Colorado law requires them to do. Callers frequently ask:

- *What is the definition of physical and sexual abuse? Does it include bullying? Emotional abuse? Educational neglect? Sexting?*
- *Child abuse is only committed between a parent and their child, right? Or can child abuse be committed by any adult upon a child?*
- *Is it child abuse if one kid sexually or physically assaults another kid?*
- *My agency requires me to report my concerns to my supervisor, is that OK or do I need to call in the report myself?*

These calls and many others like them, indicate there is room for improvement regarding how professionals respond to children they believe are suffering from abuse and neglect. The CPO conducted an in-depth analysis of Colorado's mandatory reporting law. The CPO spoke with numerous mandatory reporters, including school administrators, teachers, school resource officers, law enforcement, county human service agencies and others whose job it is to report child abuse and neglect. Additionally, the CPO reviewed mandatory reporter laws across all 50 states to gain a better understanding of how Colorado's law compares to other states.

The analysis revealed an inconsistent understanding of the law by mandatory reporters, a fragmented system of trainings and a general lack of support and resources for mandatory reporters to capably do the job asked of them – namely, to report suspected child abuse and neglect.

Colorado has consistently regarded mandatory reporting as an important child abuse prevention tool. This is evidenced by the numerous amendments that have been made to Colorado's law during the past 55 years to strengthen it. However, public policy efforts have not gone far enough to create an infrastructure that ensures our mandated reporters are able to both identify and report suspected abuse effectively.

COLORADO'S MANDATORY REPORTING LAW

Mandatory reporting laws have been around nearly five decades.

Colorado was the first state in the nation to adopt a mandatory reporting law in 1963. Since that time, the Child Protection Act of 1987 has been amended at least 31 times.[3] The most significant changes over the years have been the addition of specific types of professionals who are required to report suspected child abuse and neglect. None of the statutory amendments have created a cohesive infrastructure to ensure *quality* reporting.

The idea behind mandatory reporting laws is simple – children do not possess the maturity, physical strength, emotional capacity or resources to protect themselves. As such, they rely upon adults to be their voice, to speak on their behalf, to get them help. There are many dynamics that deter children from reporting abuse: fear that they won't be believed, fear of getting a caregiver in trouble, fear that the abuse will only get worse if it is reported.

Mandatory reporting laws are designed to have adults, who have frequent contact with children, to report suspected abuse and neglect to authorities. While all states have mandatory reporting laws, the details vary from state to state.[4]

[1] Children's Hospital Colorado has denied these allegations. The hospital's policy does not prohibit staff from filing reports directly to law enforcement and/or human services agencies.

2 See "Children's Hospital Colorado chose not to report caregivers' abuse suspicions before Olivia Gant died, records show" (Denver Post, June 13, 2021).

[2] See "Colorado Public Schools are paying millions to settle lawsuits when educators fail to report sex abuse of student, but those educators avoid legal consequences" (Denver Post, June 15, 2018)

[3] See C.R.S. § 19-3-301

[4] Child Welfare Information Gateway, Mandatory Reporters of Child Abuse and Neglect, 2019.

Colorado's mandatory reporting law lists nearly 40 different types of professionals who are required to report suspected child abuse and neglect. The law requires "any person who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect" to immediately report such information to a county human service agency, law enforcement agency or to the state child abuse hotline.[5] The law also defines what information must be reported. It is a class three misdemeanor for willfully violating the law and reporters will be provided immunity if they make a child abuse report in good faith.[6] A person cannot be fired for complying with the state's mandatory reporter law.[7]

At first look, Colorado's law appears straightforward. However, in application it challenges those who are bound by it as well as those who are required to enforce it.

WHY IS MANDATORY REPORTING SO HARD?

A quick internet search of child abuse reveals thousands of pictures of children who are bruised and battered. This would lead a person to believe the job of a mandatory reporter is obvious, if not easy. How could a reporter not understand what child abuse is? You know it when you see it, right?

Wrong. These stereotypical images, as well as the nuances surrounding child abuse dynamics, impact citizens' ability to recognize abuse let alone report it. For example, in physical abuse cases, it is not uncommon for abusers to hurt children in places where clothing can hide marks and bruises. Sexual abuse cases, rarely if ever, leave evidence of harm given the broad spectrum of sexual contact that can occur. And in neglect cases, children will frequently deny that they need food, clothing or medical attention. Rather, they adapt to have their needs met — they will surreptitiously steal food and needed articles of clothing or isolate themselves from others to avoid explaining hygiene problems. Studies confirm that children routinely act to protect their abuser, not to expose them. Signs of abuse and neglect are far more likely to be subtle and present in ways that are not immediately obvious, making mandatory reporters' jobs very difficult.

Complicating matters is that Colorado's mandatory reporters do not fully understand how to report child abuse or how their report fits into the broader child protection system's response to children. A 2016 survey conducted by the Colorado Department of Human Services (CDHS) showed that the biggest barriers for reporting child abuse was that many reporters could not identify "next steps" to make a report and were also concerned that they might not have enough information to make a report – confusing their duty to report with the duties of law enforcement and human services agencies whose job it is to assess and investigate whether such abuse has actually occurred.

Misunderstandings around what the law requires, as well as what constitutes child abuse and neglect, help make the case for clearer laws and enhanced training regarding Colorado's mandatory reporters.

THE CHALLENGES WITH COLORADO'S MANDATORY REPORTING LAW

Mandatory reporter laws require that specifically designated people, those who have relationships with children in the community and professional settings, report child abuse in a timely way to interrupt ongoing abuse and to prevent future abuse from occurring. As such, Colorado's law needs to reflect these goals. If the goal is to have mandatory reporters identify possible child abuse – then they must receive appropriate training to identify the signs of abuse and neglect. This is critically important to ensure that reporters have the best information possible when making the important decision to report – or not to report. If the goal is to have possible abuse reported in a timely manner – then the law must ensure reporters are educated regarding who is responsible for making a report, as well as how quickly a report must be made.

Colorado law is needlessly vague in many places and could be enhanced to give mandatory reporters greater support.

[5] See C.R.S. § 19-3-304

[6] See C.R.S. § 19-3-309

[7] See C.R.S. § 19-3-309

Ambiguity in the Law

Colorado law does not define what it means to "immediately" make a report of suspected child abuse and neglect. While this term may be seemingly obvious, the CPO has routinely handled cases in which mandatory reporters waited days before making a child abuse report – delaying because of workday constraints or wanting to run a set of facts by a trusted colleague prior to reporting. Some states define "immediate" as having to make a child abuse report no later than 24 hours,[8] 36 hours[9] or 48 hours[10] once child abuse is suspected. Defining this term would give clarity to mandated reporters and would ensure that children who may be in danger are having their needs met in a timely manner.

Another area of confusion is *who* is responsible for making the child abuse report. The mandated reporter or the institution for whom they work? Institutional reporting is one of the issues raised in the Olivia Gant case and is one of the most frequently asked questions that the CPO hears. During the past several years, the CPO has received dozens of calls from mandatory reporters in large organizations, including educators, hospital staff and day care centers. They frequently ask whether the law requires them to make a child abuse report directly to designated authorities or whether it is sufficient to notify their supervisor to satisfy their legal reporting responsibility.

Many individuals who contact the CPO state that their employers have policies that require them to bring child abuse concerns to an agency administrator, who will in turn file a report with the appropriate authorities. In these circumstances, it is unclear whether supervisors are substituting their judgement for that of their employees or whether they simply serve as a pass through for the information. Either way, mandatory reporters have expressed that they are fearful that such practices increase the likelihood that their information is inaccurately relayed or not relayed at all, creating unnecessary delays and possible harm to children.

The CPO has confirmed that there are some large organizations that require employees to report concerns of child abuse to supervisors or administrators first. These organizations articulate several benefits of doing so, including avoiding duplicate reports from an organization, ensuring that such reports are substantiated by facts and not personal bias and the desire to provide their employees with support during the reporting process – including assistance with filling out paperwork and providing them time to make a report.

Colorado law currently imposes the duty to report child abuse on *individuals* who are listed in the statute: doctors, dentists, nurses, teachers and many others. The law does not address how institutions, facilities and other large organizations should report abuse and neglect. There are approximately 32 states with laws that address what is commonly referred to as "institutional reporting."[11]

Institutional reporting refers to those situations in which the mandated reporter is working as a staff member at an institution, such as a school or hospital, at the time abuse or neglect of a child is suspected. In these circumstances, many institutions have policies for handling reports, which typically require the person who suspects child abuse to notify the head of the institution of the abuse and the need for a report to be made, in lieu of making the report themselves.

The question about whether institutional reporting is desirable or should be permissible is a critically important conversation that needs to take place, if only because there are already many organizations engaged in the practice. For Colorado's laws to be effective, and for children to be protected, the law must be clear regarding *who* must make a report so that valuable information does not fall through the cracks and people who fail to report suspected child abuse may be held accountable.

[8] Georgia, (GA ST § 19-7-5), Vermont, (VT ST T. 33 § 4913), Iowa (I.C.A. § 232.69).

[9] California (CA Penal § 11166).

[10] Texas (V.T.C.A., Family Code § 261.101), Washington State (West's RCWA 26.44.030).

[11] Child Welfare Information Gateway, Mandatory Reporters of Child Abuse and Neglect, 2019

There are other areas of the law that also confuse reporters, including who can commit child abuse, *what* behaviors constitute child abuse and whether children can commit child abuse on one another. All these questions could be better answered with clearer laws. However, the questions are merely symptomatic of the lack of infrastructure currently in place to support mandatory reporters – namely, a lack of training.

Colorado Lacks a Statewide, Coordinated Infrastructure to Support Mandatory Reporters

In the past five decades, Colorado has grown the list of mandatory reporters from two to nearly 40. What has not kept pace is the corresponding training and infrastructure that is needed to ensure reporters are appropriately informed of their responsibilities.

There is a long-standing national debate as to how effective mandatory reporter laws are in preventing child abuse. In the effort to prevent child abuse and neglect, it is commonly believed that if there are "more eyes and ears" on children, there are more opportunities to detect and investigate reports. However, studies show that more child abuse reports do not necessarily result in a greater number of substantiated child abuse cases and that untrained reporters can contribute to an overabundance of unsubstantiated reports – draining child welfare systems of much needed resources.[12] Additionally, there is a great deal of discussion regarding how mandatory reporter laws disproportionately and unfairly impact disadvantaged families and communities of color. A factor that can only be addressed through cultural competency training.[13]

These studies provide justification for why training mandatory reporters is crucial. Reporters must be able to readily identify the signs of child abuse and neglect, be aware of implicit bias and confidently report their concerns to authorities.

In approximately 2014, the CDHS created an online mandatory reporter training and a public awareness campaign to encourage reporting and training among the public and mandatory reporters. Unfortunately, the training is not required and the public awareness campaign, while successful, was limited in duration.

Mandatory Reporters are Not Informed of Their Legal Obligations

Ultimately, the responsibility for building a strong mandatory reporting infrastructure must lie in a coordinated approach that includes both public and private entities.

Colorado law does not create a statewide notification system that informs new mandatory reporters of their obligations to report suspected child abuse and neglect. As a result, many professionals are unaware of their reporting obligations – particularly if they are not part of a larger community of mandatory reporters such as schoolteachers, physicians and social workers – professionals who work with children every day. Creating a centralized notification system that can track Colorado's 40 different categories of mandated reporters, who are employed in both the private and government sectors, is not an easy task. However, three states – California, New York and Iowa – have engaged both the government and business communities to educate mandated reporters. Under these states' laws, any person or institution that employs mandatory reporters, are required to provide a written document that explains to new employees their mandatory reporting responsibilities, as well as the protections they have when they report child abuse and neglect.[14] Such laws provide a more targeted way to educate employees in an ongoing and consistent manner.

[12] Ho, G. W., Gross, D. A., & Bettencourt, A. (2017). Universal Mandatory Reporting Policies and the Odds of Identifying Child Physical Abuse. American Journal of Public Health, 107(5), 709-716.

[13] New York law requires the Office of Children and Family Services to update training to include protocols to reduce implicit bias in the decision to respond to abuse and neglect.

[14] California (CA Penal 11166.5), New York (Ny Soc Serv 413), Iowa (IA ST 232.69).

Colorado Does Not Require Training for its Mandatory Reporters

In addition to having no notification system, Colorado does not require training for any of its mandatory reporters. Nor does it have a continuing education requirement for professionals who are routinely working with youth and are required to have a license to practice, including doctors or therapists. This means that many mandatory reporters are not receiving the valuable training that is required to appropriately respond to suspected child abuse and neglect – even though Colorado has developed an online child abuse reporter training that is free and easily accessible to the public.[15]

Of Colorado's mandatory reporters that receive training from organizations, the instruction they receive is not standardized and varies within and across disciplines. For example, the CPO reviewed dozens of school districts' mandatory reporter trainings. They all have different curricula and approaches to teaching requirements for reporters. This may be a factor as to why mandatory reporters have different understandings of what the law requires.

There are at least 10 states that require mandatory reporters to complete training. The approaches vary widely across the country. For example, Iowa requires all its mandatory reporters take a two-hour training once every three years.[16] Pennsylvania requires all its educators and health-related professionals, who require a state license to practice, complete mandatory reporting training.[17] California takes yet another approach, requiring training for educators, school personnel, day care providers and employers who have five or more employees who are minors.[18] Each of these states provide a standard training that mandatory reporters may easily access, free of charge.

Colorado has various state departments that intersect with mandatory reporters on a regular basis, including CDHS, the Department of Regulatory Affairs (DORA), the Colorado Department of Education and the Department of Public Safety. Each of these departments is responsible for regulating child safety in various contexts. These agencies could develop a coordinated, statewide approach to educating and training mandatory reporters to ensure they are provided with the knowledge and support needed to carry out their legal responsibilities in an informed way.

CONCLUSION AND RECOMMENDATION

Decades of public policy efforts in Colorado have continued to prioritize mandatory reporting laws as a tool to prevent child abuse and neglect. While the state has invested considerable resources in creating a statewide training, this is not enough to ensure the state's mandatory reporters can do the job that is asked of them. The law, though well-intentioned, has been poorly executed for years. If Colorado wants its citizens to report suspected child abuse and neglect competently and responsibly, mandatory reporters must be given the tools to do so. To do anything short of this is to risk child safety, overwhelm child welfare services and continue the disparate impact that such laws have on inadequately resourced communities and families of color.

The CPO recommends the Colorado General Assembly and stakeholders work together to amend Colorado's law to create a robust infrastructure that supports the state's mandatory reporters. Considerations should include:

- Update the law to clarify how timely reports must be made and who is responsible for reporting – individuals or institutions;
- Require employers to provide information to their employees that detail their legal obligations to report suspected child abuse and provide them resources for training – including referrals to the state's child abuse reporting training;

[15] See https://www.coloradocwts.com/mandated-reporter-training

[16] See IA ST § 232.69

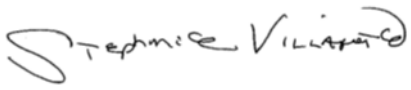
[17] See 23 Pa. C.S.A. § 6383

[18] See CA Penal § 11165.7

- Leverage existing state licensing requirements through DORA to mandate training for professionals who are mandatory reporters including doctors, nurses and psychologists;
- Require statewide trainings to be updated and include information regarding implicit bias and other factors that cause disproportionate representation of certain groups in the child welfare system; and
- Require state departments that are responsible for child safety to develop a coordinated approach to educate the state's mandatory reporters to help establish a substantive and streamlined approach that reaches reporters across the state and across various disciplines.

Child abuse in our community is a serious problem. The mandatory reporting laws created to combat the problem are outdated and not working as effectively as they can to protect our children. However, there are opportunities to make these laws better and more effective. Providing resources to build a proper mandatory reporting infrastructure as well as implementing the considerations above will go a long way to providing additional protection for our children. If we are going to require citizens to help in the fight against child abuse, then we must educate them and equip them to do the best job possible so that they understand the importance of their role in protecting Colorado children.

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.



Stephanie Villafuerte

Child Protection Ombudsman

APPENDIX B

House Bill 22-1240

HOUSE BILL 22-1240

BY REPRESENTATIVE(S) Froelich and Young, Amabile, Bernett, Boesenecker, Cutter, Gonzales-Gutierrez, Hooton, Jodeh, Kipp, Lindsay, Lontine, Michaelson Jenet, Ricks, Sullivan, Titone, Valdez A.;
also SENATOR(S) Fields and Simpson, Buckner, Cooke, Danielson, Hansen, Lee, Pettersen, Rodriguez, Story, Fenberg.

CONCERNING ENHANCING MANDATORY REPORTING FOR PEOPLE REQUIRED TO REPORT CHILD ABUSE, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

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

SECTION 1. In Colorado Revised Statutes, **amend** 19-3-302 as follows:

19-3-302. Legislative declaration. (1) The general assembly declares that the complete reporting of child abuse is a matter of public concern and that, in enacting this part 3, it is the intent of the general assembly to protect the best interests of children of this state and to offer protective services in order to prevent any further harm to a child suffering from abuse. It is also the intent of the general assembly that if a county or group of counties decides to establish a child protection team, that the child

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.

protection teams publicly discuss public agencies' responses to child abuse and neglect reports so that the public and the general assembly are better informed concerning the operation and administration of this part 3.

(2) (a) THE GENERAL ASSEMBLY FURTHER DECLARES THAT REQUIRING PEOPLE TO REPORT KNOWN OR SUSPECTED CHILD ABUSE OR NEGLECT PURSUANT TO THIS PART 3 IMPACTS THE PEOPLE REPORTING AS WELL AS CHILDREN AND FAMILIES. AS A RESULT OF IMPLICIT BIAS, UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES ARE DISPROPORTIONATELY IMPACTED BY THE MANDATORY REPORTING SYSTEM. TO CREATE A MORE EQUITABLE MANDATORY REPORTING SYSTEM, PEOPLE REQUIRED TO REPORT CHILD ABUSE OR NEGLECT MUST HAVE ACCESS TO NECESSARY RESOURCES TO REPORT CHILD ABUSE OR NEGLECT, INCLUDING BUT NOT LIMITED TO:

(I) SPECIALIZED TRAINING TO ADDRESS AND DECREASE THE DISPROPORTIONATE IMPACT ON UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES;

(II) STANDARDIZED TRAINING AND MATERIALS; AND

(III) INFORMATION REGARDING OBLIGATIONS AND PROTECTIONS PURSUANT TO THE LAW.

(b) ADDITIONALLY, THROUGH THE CREATION OF A MANDATORY REPORTER TASK FORCE IN THIS PART 3, DIVERSE REPRESENTATIVES FROM STATEWIDE ORGANIZATIONS SERVING FAMILIES AND YOUTH SHALL ANALYZE BEST PRACTICES AND MAY RECOMMEND CHANGES TO TRAINING MATERIALS AND REPORTING PROCEDURES.

SECTION 2. In Colorado Revised Statutes, **add** 19-3-304.2 as follows:

19-3-304.2. Mandatory reporter task force - creation - reporting - definitions - repeal. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "IMPLICIT BIAS" MEANS A BIAS OR PREJUDICE THAT IS PRESENT TOWARD AN INDIVIDUAL OR A GROUP OF PEOPLE WITHOUT CONSCIOUS KNOWLEDGE.

(b) "MANDATORY REPORTER" MEANS A PERSON WHO IS REQUIRED TO REPORT CHILD ABUSE OR NEGLECT PURSUANT TO SECTION 19-3-304.

(c) "MEDICAL CHILD ABUSE" MEANS WHEN A CHILD RECEIVES UNNECESSARY AND HARMFUL OR POTENTIALLY HARMFUL MEDICAL CARE DUE TO A CAREGIVER'S OVERT ACTIONS, INCLUDING EXAGGERATING THE CHILD'S MEDICAL SYMPTOMS, LYING ABOUT THE CHILD'S MEDICAL HISTORY OR FABRICATING THE CHILD'S MEDICAL HISTORY, OR INTENTIONALLY INDUCING ILLNESS IN THE CHILD.

(2) THERE IS CREATED IN THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN, ESTABLISHED PURSUANT TO SECTION 19-3.3-102, THE MANDATORY REPORTER TASK FORCE, REFERRED TO IN THIS SECTION AS THE "TASK FORCE". THE PURPOSE OF THE TASK FORCE IS TO ANALYZE BEST PRACTICES AND RECOMMEND CHANGES TO TRAINING REQUIREMENTS AND REPORTING PROCEDURES. THE TASK FORCE SHALL ANALYZE THE EFFECTIVENESS OF MANDATORY REPORTING AND ITS RELATIONSHIP WITH SYSTEMIC ISSUES, INCLUDING THE DISPROPORTIONATE IMPACT OF MANDATORY REPORTING ON UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES. THE TASK FORCE SHALL FOCUS ON SERVING UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES WHO ARE DISPROPORTIONATELY IMPACTED BY THE MANDATORY REPORTING SYSTEM. THE TASK FORCE MAY PROPOSE CLARIFICATIONS TO THE LAW TO HELP IMPLEMENT ITS RECOMMENDATIONS. THE TASK FORCE MAY MAKE FINDINGS AND RECOMMENDATIONS TO THE GENERAL ASSEMBLY, THE GOVERNOR, AND THE STATE DEPARTMENT ON ADMINISTRATIVE AND LEGISLATIVE CHANGES TO UPDATE MANDATORY REPORTER TRAINING REQUIREMENTS AND REPORTING PROCEDURES FOR REPORTING CHILD ABUSE OR NEGLECT AND TO CREATE AN EQUITABLE MANDATORY REPORTING SYSTEM FOR ALL COLORADO FAMILIES AND CHILDREN, INCLUDING HOW TO DETERMINE THE EFFECTIVENESS OF MANDATORY REPORTING AND MITIGATE THE IMPACT OF MANDATORY REPORTING ON UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES.

(3) (a) THE TASK FORCE CONSISTS OF THE FOLLOWING MEMBERS:

(I) THE CHILD PROTECTION OMBUDSMAN, AS DESCRIBED IN SECTION 19-3.3-102, OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE;

(II) ONE MEMBER REPRESENTING THE STATE DEPARTMENT TO BE APPOINTED BY THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(III) ONE MEMBER REPRESENTING THE DEPARTMENT OF PUBLIC SAFETY TO BE APPOINTED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC SAFETY, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(IV) ONE MEMBER REPRESENTING THE DEPARTMENT OF REGULATORY AGENCIES TO BE APPOINTED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF REGULATORY AGENCIES, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(V) ONE MEMBER REPRESENTING THE DEPARTMENT OF EDUCATION TO BE APPOINTED BY THE COMMISSIONER OF EDUCATION OF THE DEPARTMENT OF EDUCATION, OR THE COMMISSIONER OF EDUCATION'S DESIGNEE; AND

(VI) THE FOLLOWING MEMBERS, WHO SHALL BE APPOINTED BY THE CHILD PROTECTION OMBUDSMAN OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE:

(A) ONE MEMBER REPRESENTING A STATEWIDE EDUCATION ORGANIZATION THAT INCLUDES RURAL AREAS;

(B) ONE MEMBER REPRESENTING LAW ENFORCEMENT AGENCIES;

(C) ONE MEMBER REPRESENTING RURAL COUNTY DEPARTMENTS;

(D) ONE MEMBER REPRESENTING URBAN COUNTY DEPARTMENTS;

(E) ONE MEMBER REPRESENTING COURT-APPOINTED SPECIAL ADVOCATES, AS DEFINED IN SECTION 13-91-103;

(F) ONE MEMBER REPRESENTING THE OFFICE OF THE CHILD'S REPRESENTATIVE, AS ESTABLISHED IN SECTION 13-91-104;

(G) ONE MEMBER REPRESENTING A CHILD ADVOCACY CENTER, AS DEFINED IN SECTION 19-1-103;

(H) ONE MEMBER REPRESENTING PROSECUTING ATTORNEYS;

(I) ONE MEMBER REPRESENTING THE OFFICE OF THE STATE PUBLIC DEFENDER, AS CREATED IN SECTION 21-1-101, OR THE OFFICE OF THE ALTERNATE DEFENSE COUNSEL, AS CREATED IN SECTION 21-2-101;

(J) ONE MEMBER REPRESENTING A COUNTY ATTORNEY'S OFFICE OR A STATEWIDE ORGANIZATION REPRESENTING COUNTY ATTORNEYS' OFFICES;

(K) ONE MEMBER REPRESENTING THE OFFICE OF THE RESPONDENT PARENTS' COUNSEL, AS CREATED IN SECTION 13-92-103;

(L) ONE MEMBER REPRESENTING FAMILY LAW ATTORNEYS;

(M) ONE MEMBER REPRESENTING A STATEWIDE NONGOVERNMENTAL ORGANIZATION SPECIALIZING IN THE PREVENTION OF CHILD MALTREATMENT;

(N) ONE MEMBER FROM A STATEWIDE ORGANIZATION REPRESENTING HOSPITALS;

(O) ONE MEMBER FROM A STATEWIDE ORGANIZATION REPRESENTING MEDICAL PROFESSIONALS;

(P) ONE MEMBER FROM A STATEWIDE ORGANIZATION REPRESENTING MENTAL HEALTH PROFESSIONALS;

(Q) ONE MEMBER FROM A STATEWIDE ORGANIZATION REPRESENTING CHILDREN AND YOUTH;

(R) ONE MEMBER FROM A STATEWIDE ORGANIZATION REPRESENTING PEOPLE WITH DISABILITIES;

(S) FIVE MEMBERS REPRESENTING INDIVIDUALS WITH LIVED EXPERIENCE IN THE MANDATORY REPORTING SYSTEM;

(T) ONE MEMBER FROM A STATEWIDE ORGANIZATION SERVING UNDER-RESOURCED COMMUNITIES;

(U) ONE MEMBER WHO IS AN ACADEMIC EXPERT ON THE MANDATORY REPORTING SYSTEM EMPLOYED AT A STATE INSTITUTION OF HIGHER

EDUCATION;

(V) ONE MEMBER REPRESENTING A STATEWIDE ORGANIZATION SERVING OR REPRESENTING VICTIMS AND SURVIVORS OF DOMESTIC VIOLENCE;

(W) ONE MEMBER REPRESENTING A STATEWIDE ORGANIZATION SERVING OR REPRESENTING VICTIMS AND SURVIVORS OF SEXUAL VIOLENCE;

(X) ONE MEMBER REPRESENTING CONFIDENTIAL VICTIM ADVOCATES; AND

(Y) ONE MEMBER REPRESENTING A STATE-LICENSED CHILD CARE PROVIDER, AS DEFINED IN SECTION 26-6-102 (6).

(b) THE APPOINTING AUTHORITIES SHALL MAKE APPOINTMENTS ON OR BEFORE DECEMBER 1, 2022. IN MAKING APPOINTMENTS, THE APPOINTING AUTHORITIES SHALL SELECT MEMBERS WHO REPRESENT DIVERSE GEOGRAPHIC LOCATIONS, GENDERS, RELIGIONS, SOCIOECONOMIC STATUSES, IMMIGRATION STATUSES, AND LANGUAGES. THE TERM OF THE APPOINTMENT IS FOR THE DURATION OF THE TASK FORCE. THE APPOINTING AUTHORITIES SHALL FILL ANY VACANCY SUBJECT TO THE SAME QUALIFICATIONS AS THE INITIAL APPOINTMENT.

(4) EACH MEMBER OF THE TASK FORCE SERVES WITHOUT COMPENSATION. NONGOVERNMENTAL MEMBERS MAY BE REIMBURSED FOR REASONABLE EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES PURSUANT TO THIS SECTION.

(5) THE CHILD PROTECTION OMBUDSMAN OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE SHALL SERVE AS THE CHAIR, AND THE TASK FORCE SHALL SELECT A VICE-CHAIR FROM AMONG ITS MEMBERS. THE CHAIR AND THE VICE-CHAIR SHALL SERVE FOR THE DURATION OF THE TASK FORCE AS THE CHAIR AND THE VICE-CHAIR.

(6) (a) THE CHILD PROTECTION OMBUDSMAN, OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE, SHALL CONVENE THE FIRST MEETING OF THE TASK FORCE NO LATER THAN JANUARY 1, 2023. THE TASK FORCE SHALL MEET AT LEAST ONCE EVERY OTHER MONTH UNTIL THE TASK FORCE SUBMITS ITS FINAL REPORT. THE CHAIR MAY CALL ADDITIONAL MEETINGS AS

NECESSARY FOR THE TASK FORCE TO FULFILL ITS DUTIES. THE TASK FORCE SHALL ESTABLISH PROCEDURES TO ALLOW MEMBERS OF THE TASK FORCE TO PARTICIPATE IN MEETINGS REMOTELY.

(b) THE CHILD PROTECTION OMBUDSMAN, OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE, SHALL OPEN THE MEETINGS TO THE PUBLIC, PROVIDE ADVANCE PUBLIC NOTICE OF THE MEETINGS, AND ALLOW PUBLIC COMMENTS AT THE MEETINGS. THE CHILD PROTECTION OMBUDSMAN, OR THE CHILD PROTECTION OMBUDSMAN'S DESIGNEE, SHALL CONDUCT OUTREACH AND ENCOURAGE COMMUNITY PARTICIPATION IN THE PUBLIC MEETINGS.

(7) (a) PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE TASK FORCE, AT A MINIMUM, SHALL ANALYZE:

(I) WHETHER A STUDY SHOULD BE CONDUCTED TO DETERMINE THE EFFECTIVENESS OF MANDATORY REPORTING IN SERVING CHILDREN AND FAMILIES AND DETERMINE THE NECESSARY FUNDING FOR A STUDY. IF THE TASK FORCE DETERMINES THERE SHOULD BE A STUDY, THE STUDY MUST INCLUDE AN ANALYSIS ON WHETHER ENHANCED SCREENING TECHNIQUES FOR ACCEPTING REPORTS MAY MITIGATE THE DISPROPORTIONATE IMPACT OF MANDATORY REPORTING ON UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES.

(II) THE DISPROPORTIONATE IMPACT OF MANDATORY REPORTING ON UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES;

(III) STANDARDIZED TRAINING THAT ADDRESSES IMPLICIT BIAS;

(IV) ALTERNATIVE PROCESSES AND SERVICES FOR FAMILIES WHO DO NOT PRESENT MANDATORY REPORTERS WITH CHILD ABUSE OR NEGLECT CONCERNS BUT WHO WOULD BENEFIT FROM ALTERNATIVE SERVICES;

(V) STANDARDIZED TRAINING THAT ADDRESSES THE REQUIREMENTS OF THE LAW PURSUANT TO THIS PART 3;

(VI) THE DEFINITION OF "IMMEDIATELY" AND HOW REPORTING TIME FRAMES AFFECT MANDATORY REPORTERS FROM DIFFERENT PROFESSIONS;

(VII) REPORTING TIME FRAMES FOR MANDATORY REPORTERS WHO

ARE CREATING A SAFETY PLAN FOR VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, OR STALKING TO ENSURE THE SAFETY OF THE VICTIM AND THE VICTIM'S FAMILY MEMBERS WHILE CREATING THE SAFETY PLAN;

(VIII) MEDICAL CHILD ABUSE AND THE PROCESS TO REPORT MEDICAL CHILD ABUSE;

(IX) WHETHER MANDATORY REPORTERS SHOULD REPORT INCIDENTS OBSERVED OUTSIDE OF A MANDATORY REPORTER'S PROFESSIONAL CAPACITY;

(X) WHETHER A MANDATORY REPORTER WHO IS EMPLOYED BY, AN AGENT OF, OR A CONTRACTOR FOR AN ATTORNEY WHO IS PROVIDING LEGAL REPRESENTATION IS EXEMPT FROM THE REPORTING REQUIREMENTS DESCRIBED IN SECTION 19-3-304;

(XI) MANDATORY REPORTING REQUIREMENTS FOR MANDATORY REPORTERS WHO HAVE KNOWLEDGE OR REASONABLE CAUSE TO KNOW OR SUSPECT THAT A CHILD OR YOUTH IS THE VICTIM OF DATING VIOLENCE OR SEXUAL ASSAULT;

(XII) A REPORTING PROCESS FOR TWO OR MORE MANDATORY REPORTERS TO REPORT CHILD ABUSE OR NEGLECT WHO HAVE JOINT KNOWLEDGE OR JOINT REASONABLE CAUSE TO MAKE A REPORT OF CHILD ABUSE OR NEGLECT;

(XIII) WHETHER THE DUTY TO REPORT REMAINS WITH THE MANDATORY REPORTER WHO HAS REASONABLE CAUSE TO KNOW OR SUSPECT THAT A CHILD HAS BEEN SUBJECTED TO CHILD ABUSE OR NEGLECT;

(XIV) WHETHER INSTITUTIONS THAT EMPLOY MANDATORY REPORTERS MAY DEVELOP PROCEDURES TO ASSIST MANDATORY REPORTERS IN FULFILLING REPORTING REQUIREMENTS, AS DESCRIBED IN SECTION 19-3-307;

(XV) TRAINING REQUIREMENTS FOR PEOPLE APPLYING FOR OR RENEWING A PROFESSIONAL LICENSE FOR A PROFESSION THAT IS IDENTIFIED AS A PROFESSION REQUIRED TO REPORT CHILD ABUSE OR NEGLECT PURSUANT TO SECTION 19-3-304;

(XVI) THE PERSONAL INFORMATION OF A CHILD, AS SET FORTH IN

SECTION 19-3-307 (2), THAT IS COLLECTED FOR A REPORT;

(XVII) STANDARDIZED TRAINING REGARDING THE COUNTY DEPARTMENTS' PROCESS TO DETERMINE WHICH REPORTS MEET THE THRESHOLD FOR ASSESSMENT AND INVESTIGATION;

(XVIII) THE BENEFITS OF AN ELECTRONIC REPORTING PLATFORM FOR THE STATE; AND

(XIX) A PROCESS FOR INTER- AND INTRA-AGENCY COMMUNICATIONS, CONFIRMING RECEIPT OF REPORTS, AND, IN SOME CIRCUMSTANCES, SHARING THE OUTCOME OF REPORTS WITH CERTAIN MANDATORY REPORTERS.

(b) THE TASK FORCE MAY ESTABLISH STANDING SUBCOMMITTEES TO STUDY THE ISSUES IDENTIFIED IN SUBSECTION (7)(a) OF THIS SECTION.

(8) THE TASK FORCE SHALL ANALYZE NATIONAL BEST PRACTICES AND CONSULT WITH ADDITIONAL STAKEHOLDERS AS NEEDED TO ADDRESS ALL ADDITIONAL QUESTIONS NECESSARY TO FINALIZE ITS FINDINGS AND RECOMMENDATIONS FOR MANDATORY REPORTER TRAINING REQUIREMENTS, REPORTING PROCEDURES, AND CREATING A MORE EQUITABLE MANDATORY REPORTING SYSTEM FOR UNDER-RESOURCED COMMUNITIES, COMMUNITIES OF COLOR, AND PERSONS WITH DISABILITIES WHO ARE DISPROPORTIONATELY IMPACTED BY MANDATORY REPORTING.

(9) ON OR BEFORE JANUARY 1, 2024, THE TASK FORCE SHALL SUBMIT ITS FIRST-YEAR STATUS REPORT, INCLUDING ITS INITIAL FINDINGS AND RECOMMENDATIONS ON ISSUES IDENTIFIED IN SUBSECTION (7) OF THIS SECTION, TO THE HOUSE OF REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES; THE GOVERNOR; AND THE STATE DEPARTMENT.

(10) ON OR BEFORE JANUARY 1, 2025, THE TASK FORCE SHALL SUBMIT ITS FINAL REPORT, INCLUDING ITS FINDINGS AND RECOMMENDATIONS ON THE ISSUES IDENTIFIED IN SUBSECTION (7) OF THIS SECTION, TO THE HOUSE OF REPRESENTATIVES PUBLIC AND BEHAVIORAL HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES; THE GOVERNOR; AND THE

STATE DEPARTMENT.

(11) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2025.

SECTION 3. In Colorado Revised Statutes, 19-3-304.2, **amend as added by House Bill 22-1240** (3)(a)(VI)(Y) as follows:

19-3-304.2. Mandatory reporter task force - creation - reporting - definitions - repeal. (3) (a) The task force consists of the following members:

(VI) The following members, who shall be appointed by the child protection ombudsman or the child protection ombudsman's designee:

(Y) One member representing a state-licensed child care provider, as defined in ~~section 26-6-102 (6)~~ SECTION 26.5-5-303 (4).

SECTION 4. Appropriation. For the 2022-23 state fiscal year, $97,500 is appropriated to the judicial department for use by the office of the child protection ombudsman. This appropriation is from the general fund. To implement this act, the office may use this appropriation for program costs.

SECTION 5. Act subject to petition - effective date. (1) Except as otherwise provided in subsection (2) of this section, this act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the

people at the general election to be held in November 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) Section 3 of this act takes effect only if House Bill 22-1295 becomes law, in which case section 3 takes effect upon the effective date of this act or House Bill 22-1295, whichever is later.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Steve Fenberg
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED June 2, 2022 at 3:01 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

APPENDIX C

Membership List

Mandatory Reporting Task Force

Membership List

Effective December 2023

Appointment	Name	Organization/Experience
The Child Protection Ombudsman, or the Ombudsman's designee (See C.R.S. §19-3-304.2(3)(a)(I))	Stephanie Villafuerte	Colorado Child Protection Ombudsman, Office of Colorado Child Protection Ombudsman
A representative of the Colorado Department of Human Services, appointed by the Executive Director or the Executive Director's designee. (See C.R.S. §19-3-304.2(3)(a)(II))	Yoland Arredondo	Deputy Director, Division of Child Welfare
A representative of the Department of Public Safety, appointed by the Executive Director or the Executive Director's designee. (See C.R.S. §19-3-304.2(3)(a)(III))	Margaret Ochoa	Manager, Colorado School Safety Resource Center
A representative of the Department of Regulatory Agencies, appointed by the Executive Director or the Executive Director's designee. (See C.R.S. §19-3-304.2(3)(a)(IV))	Vacant	
A representative of the Department of Education, appointed by the Executive Director or the Executive Director's designee. (See C.R.S. §19-3-304.2(3)(a)(V))	Colleen O'Neil	Associate Commissioner
A representative of a statewide education organization that includes rural areas.	Michelle Murphy	Executive Director, Colorado Rural School Alliance

(See C.R.S. §19-3-304.2(3)(a)(VI)(A))		
A representative of law enforcement agencies. (See C.R.S. §19-3-304.2(3)(a)(VI)(B))	Carlos Castillo	Sergeant, Denver Police Department
A representative of a rural county department of human services. (See C.R.S. §19-3-304.2(3)(a)(VI)(C))	Nicci Surad	Child Welfare Supervisor, Mesa County Department of Human Services
A representative of an urban county department of human services. (See C.R.S. §19-3-304.2(3)(a)(VI)(D))	Michelle Dossey	Child and Adult Protection Services Division Manager, Arapahoe County Department of Human Services
A representative of court-appointed special advocates. (See C.R.S. §19-3-304.2(3)(a)(VI)(E))	Zane Grant	Executive Director, CASA of Pueblo County
A representative of the Office of the Child's Representative. (See C.R.S. §19-3-304.2(3)(a)(VI)(F))	Ashley Chase	Staff Attorney and Legislative Liaison, Office of the Child's Representative
A representative of a child advocacy center. (See C.R.S. §19-3-304.2(3)(a)(VI)(G))	Lori Jenkins	Executive Director, Kindred Kids Child Advocacy Center
A representative of prosecuting attorneys. (See C.R.S. §19-3-304.2(3)(a)(VI)(H))	Jessica Dotter	Sexual Assault Resource Prosecutor, Colorado District Attorneys' Council
A representative of the Office of the State Public Defender or the Office of the Alternative Defense Counsel. (See C.R.S. §19-3-304.2(3)(a)(VI)(I))	Kevin Bishop	Social Worker Coordinator, Office of the Alternative Defense Counsel

A representative of a county attorney's office or a statewide organization representing county attorneys' offices. (See C.R.S. §19-3-304.2(3)(a)(VI)(J))	Adriana Hartley	Assistant County Attorney, Office of the Delta County Attorney
A representative of court-appointed special advocates. (See C.R.S. §19-3-304.2(3)(a)(VI)(K))	Jill Cohen	Chief Operating Officer, Office of Respondent Parents' Counsel
A representative of family law attorneys. (See C.R.S. §19-3-304.2(3)(a)(VI)(L))	Leanna Gavin	Kalamaya | Goscha
A representative of a statewide nongovernmental organization specializing in the prevention of child maltreatment. (See C.R.S. §19-3-304.2(3)(a)(VI)(M))	Jace Woodard	Executive Director, Illuminate Colorado
A representative of a statewide organization representing hospitals. (See C.R.S. §19-3-304.2(3)(a)(VI)(N))	Kelsey Wirtz	Licensed Clinical Social Worker | Peds/PICU/Gynecology, Dener Health Medical Center
A representative of a statewide organization representing medical professionals. (See C.R.S. §19-3-304.2(3)(a)(VI)(O))	Kathryn Wells	Pediatrician and Executive Director, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
A representative of a statewide organization representing mental health professionals. (See C.R.S. §19-3-304.2(3)(a)(VI)(P))	Donna L. Wilson	Ph.D., Director of Clinical Operations and Community Engagement, WellPower
A representative of a statewide organization representing children and youth. (See C.R.S. §19-3-304.2(3)(a)(VI)(Q))	Kaycee Headrick	Boys & Girls Club

A representative of a statewide organization representing people with disabilities. (See C.R.S. §19-3-304.2(3)(a)(VI)(R))	Sara Pielsticker	Staff Attorney, Disability Law Colorado
An individual with lived experience in the mandatory reporting system. (See C.R.S. §19-3-304.2(3)(a)(VI)(S))	Sam Carwyn	Families Minister
An individual with lived experience in the mandatory reporting system. (See C.R.S. §19-3-304.2(3)(a)(VI)(S))	Tara Doxtater	Recovery Coach/Parent Advocate, Office of the Respondent Parents' Counsel
An individual with lived experience in the mandatory reporting system. (See C.R.S. §19-3-304.2(3)(a)(VI)(S))	Nathaniel Hailpern	Parent Advocate, Office of the Respondent Parents' Counsel
An individual with lived experience in the mandatory reporting system. (See C.R.S. §19-3-304.2(3)(a)(VI)(S))	Shayna Koran	Parent Advocate, Office of the Respondent Parents' Counsel
An individual with lived experience in the mandatory reporting system. (See C.R.S. §19-3-304.2(3)(a)(VI)(S))	Cris Menz	Licensed Clinical Social Worker, LotusOM, LLC
A representative of a statewide organization serving under-resourced communities. (See C.R.S. §19-3-304.2(3)(a)(VI)(T))	Shawna McGuckin	Membership Manager, Family Resource Center Association
A member who is an academic expert on the mandatory reporting system employed at a	Ida Drury	Ph.D., Assistant Professor | University of Colorado | Department of Pediatrics

state institution of higher education. (See C.R.S. §19-3-304.2(3)(a)(VI)(U))		
A representative of a statewide organization serving or representing victims and survivors of domestic violence. (See C.R.S. §19-3-304.2(3)(a)(VI)(V))	Roshan Kalantar	Executive Director, Violence Free Colorado
A representative of a statewide organization serving or representing victims and survivors of domestic violence. (See C.R.S. §19-3-304.2(3)(a)(VI)(W))	Gina Lopez	Systems Response Program Director, Colorado Coalition Against Sexual Violence
A representative of confidential victim advocates. (See C.R.S. §19-3-304.2(3)(a)(VI)(X))	Jennifer Eyl	Executive Director, Project Safeguard
A representative of a state-licensed child care provider. (See C.R.S. §19-3-304.2(3)(a)(VI)(Y))	Dawn Alexander	Executive Director, Early Childhood Education Association

APPENDIX D

Charter

Mandatory Reporting Task Force Charter

Introduction

On September 15, 2021, the Office of the Colorado Child Protection Ombudsman (CPO) issued a brief detailing its study of Colorado's mandatory reporting law. The CPO initiated that study in response to repeated inquiries from citizens, professionals and mandatory reporters themselves, seeking clarification regarding what the law requires of them. The CPO spoke with numerous mandatory reporters, including health professionals, school administrators, teachers, school resource officers, law enforcement, county human service agencies and others whose job it is to report child abuse and neglect. During these conversations, many urged the CPO to also consider how mandatory reporting disproportionately impacts families of color and under-resourced communities.

The CPO's analysis of issues revealed an inconsistent understanding of the law by mandatory reporters, a fragmented system of trainings for mandatory reporters and a general lack of support and resources for mandatory reporters to capably do the job asked of them – namely, to report suspected child abuse and neglect. This report culminated in the creation of House Bill 22-1240, which established the Mandatory Reporting Task Force (Task Force).

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

Mission

This critical task force is established to analyze the effectiveness of mandatory reporting and its relationship with systemic issues, including the disproportionate impact of mandatory reporting on under-resourced communities, communities of color and persons with disabilities. The Task Force will analyze whether Colorado's mandatory reporting system is the most effective way to help and/or support children and families and may develop recommendations regarding secondary support systems, training and other issues identified by the Task Force.

Charge

Pursuant to HB 22-1240, the Task Force is required to analyze:

- Whether a study should be conducted to determine the effectiveness of mandatory reporting in serving children and families and determine the necessary funding for a study. If the Task Force determines there should be a study , the study must include an analysis on whether enhanced screening techniques for accepting reports may mitigate the disproportionate impact of mandatory reporting on under-resourced communities, communities of color and persons with disabilities.

- The disproportionate impact of mandatory reporting on under-resourced communities, communities of color and persons with disabilities.
- Standardized training that addresses implicit bias.
- Alternative processes and services for families who do not present mandatory reporters with child abuse or neglect concerns but who would benefit from alternative services.
- Standardized training that addresses the requirements of Colorado's mandatory reporting law.
- The definition of "immediately" and how reporting time frames affect mandatory reporters from different professions.
- Reporting time frames for mandatory reporters who are creating a safety plan for victims of domestic violence, sexual assault or stalking to assure the safety of the victim and the victim's family members while creating the safety plan.
- Medical child abuse and the process to report medical child abuse.
- Whether mandatory reporters should report incidents observed outside of a mandatory reporter's professional capacity.
- Whether a mandatory reporter who is employed by, an agent of, or a contractor for an attorney who is providing legal representation is exempt from the reporting requirements.
- Mandatory reporting requirements for mandatory reporters who have knowledge or reasonable cause to know or suspect that a child or youth is the victim of dating violence or sexual assault.
- A reporting process for two or more mandatory reporters to report child abuse or neglect who have joint knowledge or joint reasonable cause to make a report of child abuse or neglect.
- Whether the duty to report remains with the mandatory reporter who has reasonable cause to know or suspect that a child has been subjected to child abuse or neglect.
- Whether institutions that employ mandatory reporters may develop procedures to assist mandatory reporters in fulfilling reporting requirements.
- Training requirements for people applying for or renewing a professional license for a profession that is identified as a profession required to report child abuse or neglect.
- The personal information that is collected for a report.
- Standardized training regarding the county department's process to determine which reports meet the threshold for assessment and investigation.
- The benefit of an electronic reporting platform.
- A process for inter- and intra-agency communications, confirming receipt of reports, and, in some circumstances, sharing the outcome of reports with certain mandatory reporters.

Definitions (see other sections for more detailed descriptions):

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

- **Factiliation Team:** Each meeting will be supported and facilitated by the Keystone Policy Center (Keystone). Keystone was established in 1975 and is an independent non-profit organization. They have helped public, private and civic-sector leaders solve complex problems and advance good public policy for more than 40 years in Colorado and nationally. Keystone does not advocate for any policy position but rather works to ensure that stakeholders share decision making and work together to find mutually agreeable solutions to complex problems.
- **Co-Chairs:** Co-chairs of the Task Force will serve in an advisory role to Keystone, between meetings to assist with assessing progress and setting agendas for Task Force discussions. They will be available to members to provide feedback and guidance.
- **Work Groups:** Forums composed of members and implementing partners that are focused on coordinating and aligning efforts in executing official and endorsed projects of the task force.

Task Force Outcomes

Per HB 22-1240, the Task Force must submit a first year status report and a final report to the House Public & Behavioral Health & Human Services Committee and the Senate Health & Human Services Committee. The first-year status report must be submitted by January 1, 2024, and the final report must be submitted by January 1, 2025. The CPO will also broadly disseminate the report to the public and members of the media.

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

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

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

Ground Rules

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

Media Protocols

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

- Only use messaging that has been agreed upon by the Task Force and approved by Keystone when characterizing the Task Force on behalf of its members, and when characterizing the roles and commitments of members.
- Be clear to delineate your own opinion or interest from the agreed-upon messaging of the Task Force.
- Do not characterize or attribute the opinions or positions of other members.
- Press releases of/on behalf of the Task Force will be reviewed by the CPO prior to their release. CPO will coordinate the development, review and submission of media releases with the Task Force under a timely process.

- Individual members should not make announcements on behalf of the Task Force. Members planning their own media releases and/or other formal communications that reference or characterize the Task Force – including but not limited to web copy and presentations – should submit the draft materials to Keystone for review at least one week prior to the intended public release date. Keystone will review the materials for consistency with agreed-upon messaging and, where necessary, coordinate with task force members for further review.

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