

**FINAL REPORT**

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# Timothy Montoya Task Force Final Report



**CHILD PROTECTION**  
**OMBUDSMAN**  
of COLORADO



**KEYSTONE**  
POLICY CENTER



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# Introduction

Every year, children and youth who are placed into the care of residential treatment facilities or foster homes run away from these placements.

There is little information about where these children and youth go or what happens to them while they are missing. However, national research has made clear the substantial and life changing dangers that they face. Still, Colorado has no standard protocols in place to stop them. Colorado has no standard system in place to help find them. Colorado has no consistent method of providing assessment and care for when they return. For decades, Colorado has failed to recognize the urgency and prevalence of the dangers facing these children and youth. This urgency has been veiled behind the anecdotes that the majority of children and youth return. But the reality is not all do.

By the time Timothy Montoya ran away from his residential facility in 2020, the 12-year-old had already experienced nearly a dozen short-term and long-term hospitalizations and stays in residential care facilities. He had complex behavioral health issues including autism, attention deficit hyperactivity disorder and post-traumatic stress disorder. These contributed to him habitually running away from care. Unfortunately, there was no statewide data system in place where this information could be shared with his many care providers. Timothy also had a history of self-harming behaviors and placing himself in dangerous situations while he was away from care. But there was no standard statewide assessment tool to help providers assess his likelihood of running away or the risks he faced once he left care. Timothy's mother knew that her son had a habit of running away. But she had no knowledge that the providers caring for her son would not physically try to stop him and that there is no state requirement to find him. None of these systems were in place when Timothy was hit and killed by a car more than four years ago. None of these systems are in place today.

**When Timothy Montoya ran away from his residential facility in 2020, the 12-year-old had demonstrated a habit of running away from care. But there was no statewide system in place to share that information.**

Named in his memory, the Timonthy Montoya Task Force to Prevent Youth from Running from Out-of-Home Care was convened by the legislature to study and find ways to improve the systems and programs that will help prevent children and youth from running away from care. The task force was charged with determining how to improve the protocols for locating children and youth while they are on the run and for bolstering the care provided to children and youth when they return. What the task force quickly found was that there are no standard, statewide systems or programs to address the care of these children and youth. Additionally, Colorado has no standard, statewide process for collecting information and data regarding why children and youth run away from care, what happens to them while they are gone and what services are provided to them after they are located. What data does exist cannot be extracted in a manner that effectively helps demonstrate the scope of the issue or the experiences of the children and youth. As such, professionals have been forced to rely on anecdotal evidence when seeking to make reforms. This issue has been compounded by a lack of clarity in the law regarding who is responsible for preventing children and youth from running away from care, for locating them when they leave care and ultimately returning them to safety.

During the past two years, the 22-member task force has worked to meticulously dissect these issues and identify possible solutions to establish the infrastructure desperately needed to address these concerns and put these systems in place. Here the task force is proud to present its recommendations to address these issues and hopes this report will shed light on the urgency of the issue.

# History of the Task force

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 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 children and 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 children and 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.”<sup>1</sup> 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 administering the task force and ensuring a neutral and inclusive space for members to carry out their work.

# Task Force Overview

## Charge and Directives

The General Assembly established the task force to ensure there was a thorough and thoughtful analysis of the root causes for why children and youth run away from care – including out-of-home-placements such as foster homes or residential treatment facilities.<sup>2</sup> Task force members were charged with analyzing current laws, regulations and practices regarding how providers and agencies respond to children and youth who run away from care. They were also tasked with developing a consistent, prompt and effective response for when children and youth run away from care, processes for promoting their care and well-being upon their return and programs to deter children and youth from running from care to begin with. In total, the task force was required to address eight directives.<sup>3</sup>

## Membership and Attendance

The task force was comprised of 22 individuals. These members included young people who were previously in out-of-home placements, family members whose children have run from out-of-home placements, members of law enforcement and professionals who are responsible for the care of children and youth in out-of-home placements including residential child-care providers, child welfare human service providers, non-profit organizations, foster parents and others.<sup>4</sup> To solicit applications, the CPO launched a statewide campaign through social media and other communications efforts, as well as worked 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 22-1375, as well as professional and lived experience.<sup>5</sup>

<sup>1</sup> See [House Bill 22-1375](#).

<sup>2</sup> See [C.R.S. §19-3.3-111\(1\)\(d\)](#) and [C.R.S. §19-3.3-111\(1\)\(e\)](#).

<sup>3</sup> See [C.R.S. §19-3.3-111\(5\)](#).

<sup>4</sup> See [Task Force Member Appointment List](#).

<sup>5</sup> See [C.R.S. §19-3.3-111\(3\)](#).





Colorado's state-licensed residential treatment facilities provide critically important services to some of the state's most high needs children and youth, including those with severe behavioral health needs.

Throughout the duration of the task force, the CPO worked to fill vacancies on the task force. Pursuant to House Bill 22-1375, the Child Protection Ombudsman served as chair of the task force and members were 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.

nor does the CPO represent the children, youth and families impacted by them. This neutrality and separation are by design. Given its position, the CPO was determined to be best suited to create the inclusive and impartial space needed to address this long-standing issue. Equally important, the CPO, by statute, ensured the work of this task force was public-facing and easily accessible.

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## Placement within the CPO

Colorado's state-licensed residential treatment facilities provide critically important services to some of the state's most high needs children and youth, including those with severe behavioral health needs. The CPO has closely monitored the services offered at these facilities, studied the laws and regulations that guide how such placements are monitored and managed and engaged with families that have experienced placements at these facilities. Since 2019, the CPO has published briefs and publicly discussed its concerns regarding these systems – including the need to address the safety and care of children and youth who run away from out-of-home care. Long before the passage of HB 22-1375, the CPO was working with stakeholders to address these issues.

The CPO is uniquely situated to effectively address such concerns. Situated as an independent state agency, the CPO does not represent any of the agencies or facilities involved in these placements,

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## Facilitation and Support

The CPO contracted with the Keystone Policy Center (Keystone) to facilitate task force meetings and provide additional support to members. Keystone was primarily tasked with providing facilitation of task force meetings and promoting the full participation of task force members. When necessary, Keystone worked to help members resolve their differences and work toward resolving concerns. Keystone ensured adequate stakeholder engagement and worked with task force members to develop a working charter.<sup>6</sup> This charter provided members with guidance regarding the charge of the task force, ground rules for engagement and standards for media engagement.

Additionally, the CPO worked to provide the task force with original research necessary to help address the task force's directives. This included in-depth research regarding the programs and practices utilized in other states and additional information about current resources in Colorado. To accompany

<sup>6</sup> See [Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement Charter](#).

this research, the CPO also worked to coordinate guest speakers with various expertise and experience in Colorado and other states. The task force was also provided a collection of research articles and statutory analysis.<sup>7</sup>

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## Voting Structure

The task force operated under the understanding that its findings and recommendations do not necessitate consensus among its members. This report captures the diverse opinions and robust discussions held by members. During its tenure, task force members were asked to take polls to help guide the facilitation team regarding members' alignment with the direction of the task force and recommendations. These discussions and findings are captured in written summaries of each meeting, meeting minutes and the two reports required by law.<sup>8</sup>

This report captures recommendations approved by the majority of task force members. Prior to the publication of this report, each task force member was asked to take a position on the final recommendations.<sup>9</sup> Additionally, all task force members were given the opportunity to submit a written explanation of their dissent for any recommendations contained in this report.<sup>10</sup> Finally, if a task force member abstained from a final vote, they were asked to provide a written notification of their abstention.<sup>11</sup>

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## Transparency

All meetings were open to the public, welcoming valuable input and insights from attendees. Pursuant to HB 22-1375, the CPO worked to promote each meeting by sending out media advisories and posting information about each meeting on the CPO's website.<sup>12</sup> In addition to inviting members of the public to present during various meetings, information shared during public comment often helped shape the topics raised for discussion or inspired ideas to explore further. Comments from members of the public are contained in meeting

minutes. Additionally, each meeting was recorded, and links to those recordings were posted to the CPO's website in full. Meeting materials, meeting summaries and other materials are also posted to the CPO's website.

During the course of the task force's 24 months, members met a total of 23 times.<sup>13</sup> While HB 22-1375 only required the task force to meet every other month, members opted to begin meeting monthly to ensure adequate time to address each directive and develop thoughtful recommendations.

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## Creating a Common Language

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 can imply that these children have full adult decision-making capabilities when in reality there are complex factors that may lead them to leave care, including coercion by external parties and a child or youth's behavioral health considerations. It was suggested that a more suitable 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 child or 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.

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## Recommendations for Children and Youth Who Run from Foster Care and Residential Facilities

<sup>7</sup> See [description and links to full list of the materials and research provided by the CPO](#).

<sup>8</sup> See [C.R.S. §19-3.3-111\(7\)](#).

<sup>9</sup> See [Final Task force Member Voting](#).

<sup>10</sup> See [Member Position Statements for Final Recommendation "No" Votes](#).

<sup>11</sup> See [Member Abstention Letters](#).

<sup>12</sup> See the [CPO's website for the task force](#).

<sup>13</sup> See [Meeting Dates of the Timothy Montoya Task force](#).

In HB 22-1375, the task force was charged with considering the impacts of running away from care for children and youth who are residing in residential facilities and foster care homes.<sup>14</sup> Task force members unanimously acknowledged the risks that children and youth face when they run from either of these placement settings. Throughout the two years of task force discussions, members were provided with national research and data concerning children and youth in both foster care and residential facility settings, as well as several panelists with professional and lived experience.

While task force discussions and much of this report addresses instances of children and youth running away from residential facilities, members agreed that the majority of recommendations issued in this report apply to children and youth in both placement settings. This includes recommendations to create standard, statewide systems that would provide care, assessment and information key to protecting these children and youth. The minority of recommendations that are specific to facility settings fall into two categories. One involves considerations for enhancing the physical infrastructure of the residential facilities. Such enhancements – such as fencing, signage and alarms – would not be appropriate in foster care placements. The second category contains the recommendations for Directive 5. This directive specifically asked the task force to consider state law and regulations as they relate to facility placements. As such, the recommendations issued in this section of the report are responsive to that charge.

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## Identifying the Children and Youth Who Run from Out-of-Home Care

The task force’s overarching charge was 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.”<sup>15</sup> To effectively meet this charge, the task force had to

ensure its analysis and discussions were centered on the children and youth most impacted by the issues detailed in the legislation – those who are most vulnerable to the inherent risks of running away from care. To begin this work, the task force was provided information and data by the Colorado Department of Human Services (CDHS). According to data presented by CDHS to the task force<sup>16</sup>, 266 children ran from out-of-home placement in Colorado in 2022. The task force was not presented with information regarding the amount of time that children and youth are away from care, or the number of children and youth who never return to care. There was an early recognition by CDHS members that current data was unable to answer a variety of key questions, and it is extremely difficult to extract information from current systems. Specifically, there is currently no standard, statewide system to effectively track the children and youth who run away from care and the risks they encounter while away from care. The lack of state-specific data also prevented the task force from accurately identifying the potential disparity impacts these issues have on children and youth of color. Unable to effectively determine which populations are most impacted in Colorado, the task force relied on research completed in other states and anecdotal information to help focus its discussions.

While task force discussions and much of this report addresses instances of children and youth running away from residential facilities, members agreed that the majority of recommendations issued in this report apply to children and youth in both placement settings.

<sup>14</sup> See [C.R.S. §19-3.3-111\(1\)\(d\)](#).

<sup>15</sup> See [C.R.S. §19-3.3-111\(2\)\(a\)](#).

<sup>16</sup> See [presentation slides](#).

## What Other States Have Found

Generally, children and youth of color are disproportionately represented in Colorado's child welfare system. However, there is no way to determine if that trend correlates with the children and youth who run away from care. As such, the task force relied on research and studies conducted in other states as a starting point to discussing the disparate risks associated with running away from care. One study reviewed by the task force found that children and youth missing from out-of-home care are more likely to be Black and less likely to have their race listed as "unknown," compared to children and youth missing from their family of origin.<sup>17</sup> These children and youth are also at greater risk of experiencing criminal or sexual victimization, drug or alcohol abuse, criminal activity and human trafficking.

As research regarding this issue has increased in other states, more information is known about individual risk factors that may increase the likelihood that a child or youth will run away from care. These factors include:

- » Children and youth who are removed from their homes at an older age are more likely to run than those who were younger when they were first removed from their family of origin.
- » Children and youth of color are more likely to run away from care. However, research is unclear regarding whether children from a particular racial or ethnic group are more likely to run away.

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)."<sup>18</sup> The study examined the factors associated with children running away from foster care. It found that removal from the home due to a child's substance use was strongly associated with an increased risk of running away from care, as was abandonment and behavioral problems.<sup>19</sup> 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.

<sup>17</sup> See [Nystrom, A., Wood, H., Cox, L., Richards, T.N., & Gross, M. \(2022\). Special Report: Examining Missingness among Children in Out-of-Home Care Placements in Nebraska. Submitted to the Nebraska Legislator, February 7, 2022.](#)

<sup>18</sup> See [full report](#).

<sup>19</sup> See [presentation slides](#).

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## Elevating Lived Experience in Colorado

Again, because there is no Colorado-specific research or qualitative data, the task force was required to start from scratch to collect anecdotal evidence about why children and youth run away from care and their experiences while away from care. The task force approached this work through two venues. The first was the completion of a required commissioned study. To aid the task force in its analysis of the root causes for children and youth running away from care, the CPO contracted with the University of Denver's Colorado Evaluation & Action Lab (The Lab) to facilitate a series of focus groups with children, youth and staff currently residing in residential facilities.<sup>20</sup> The results of that report are detailed later in this report.

Second, the CPO and facilitation team invited individuals who have history involving 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 children and 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 behavioral health needs of the children and youth in their care. Additionally, all called for a stronger sense of urgency when a child or youth runs away from care. The second panel featured adults who ran away from their out-of-home placements as children and youth, and 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 home of origin and/or parents, regardless of circumstances.

<sup>20</sup> See [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.](#)





# Analysis & Recommendations

## Task Force Purview

Pursuant to its enabling statute, the task force was charged with analyzing “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.”<sup>21</sup> This charge required the task force to consider children and youth who run away from residential facilities and foster care homes.<sup>22</sup>

While many of the task force’s discussions were centered around the circumstances presented by children and youth who run away from residential facilities, the discussions encompass the general urgency and issues impacting the cause, response and care of children and youth who run from foster homes as well.

The eight specific directives articulated in the enabling statute charged the task force with considering practice and standards not only in Colorado, but nationally as well. This breadth allowed the task force to repeatedly look to jurisdictions outside of Colorado for ideas and lessons on how to address these issues. This information proved to be key in forming recommendations and assessing what is working well and what needs improvement in Colorado.

Finally, it should be noted that the task force was not required to issue recommendations for each directive. However, after two years of in-depth conversations and work, the task force identified recommendations to address each issue presented.



## Task Force Analysis and Recommendations

Accompanying each directive is a detailed summary of the discussions held by the task force. These summaries are intended to provide readers with a sense of the process that led to the ultimate recommendation, as well as to provide guidance and context for the implementation of each recommendation. It is anticipated that future implementation of these recommendations will be done in collaboration with and the expertise of task force members of the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement.



## DIRECTIVE ONE

### Analyze the sufficiency of statewide data regarding the experiences of children who have run away from care.

Task force members quickly recognized the need for data concerning the frequency and duration regarding the incidents of children and youth who run away from care. Members also quickly identified the need for consistent data regarding the child or youth's reasons for running away and information about the experiences of children and youth while they are away from their out-of-home placements. In short order, the majority of members acknowledged that both quantitative and qualitative data regarding the experiences of children and youth who run away from care in Colorado is insufficient.

To inform these discussions, the task force was first provided with information regarding requirements under current federal and state law – and state regulations – for reporting when a child or youth runs away from care.

#### Data Collection and Reporting Requirements Under Federal and State Law

The task force was provided with an overview of federal and state laws that determine reporting requirements and protocols for when children and youth run away from care. Current federal law requires states to develop and implement specific protocols for such instances. Specific protocols include:

- » Expediently locating missing foster youth;
- » Determining factors that contributed to the youth's running away, and if possible, responding to those factors in current and subsequent placements;
- » Determining the youths' experiences while absent from care, including screening for sex trafficking; and reporting to law enforcement authorities immediately and in no case longer than 24 hours after receiving information on a missing or abducted youth.<sup>23</sup>

Colorado law distinguishes reporting requirements for missing children and youth, from children and

youth who run away from foster homes and out-of-home placement facilities. County departments with legal custody of a child or youth are required to report immediately, and in no case later than 24 hours, to the National Center for Missing and Exploited Children (NCMEC) and to law enforcement after learning of the disappearance of a youth.<sup>24</sup> Additionally, state law also establishes reporting requirements for foster parents and out-of-home placement facilities. When children or youth who are detained, committed to the department of human services or otherwise sentenced or placed in out-of-home placements pursuant to 19-2.5-1103, runs away from a facility or home in which they are placed, the person in charge of the facility or foster family must notify the court and local law enforcement as soon as possible after discovering the juvenile has run away.<sup>25</sup>

The Colorado Department of Human Services (CDHS) serves as the licensing and monitoring authority of all providers offering services and out-of-home care, including residential providers, child placement agencies, day treatment facilities and adoption agencies in Colorado. CDHS is also the entity charged with overseeing the data collection and analysis for facilities and county departments in the state. Currently, there is no standard, statewide system that effectively collects information and data regarding instances of children and youth running away from care, nor is there a current system that allows for the extraction of this information in a way that would allow for meaningful analysis. CDHS acknowledged that the statewide child welfare database, Trails, does not have these capabilities

**Currently, there is no standard, statewide system that effectively collects information and data regarding instances of children and youth running away from care...**

<sup>23</sup> See [Title IV-E \(42 U.S.C. § 671\(35\)\)](#).

<sup>24</sup> See [C.R.S. § 19-1-115.3](#) and [CO Code of Regs. Tit. 12, § 2509-4\(7.303.4\)](#).

<sup>25</sup> See [C.R.S. § 19-2.5-1508](#) and [CO Code of Regs. Tit. 12, § 2509-4 \(7.303.4\)](#).

Additionally, there are few tools available to providers, county departments of human services and others to help them document the information required by federal law. For example, the High-Risk Victimization (HRV) tool is used by several providers and professionals to guide conversations with children and youth after they return to care. However, task force members noted several concerns with the limited information collected by the tool and the inconsistent use of the tool. For example, some providers will fill out the tool by hand and enter narrative data into Trails.<sup>26</sup> However, this information cannot be easily extracted from the system. Others will fill out the tool electronically, but they are then limited to yes or no responses when additional context may be helpful. Additionally, there is no standard, statewide training for how to use the tool, when children and youth should be interviewed or when the information should be entered into the system. Effectively, key questions regarding the experiences of children and youth while

**The majority of members agreed that data should be able to demonstrate the “why” behind children and youth who run away from care.**

they are out of care remain unanswered hindering a comprehensive understanding of the scope of the issue and the hazards and dangers encountered by children and youth while out of care.

Of particular concern for task force members, is the inability to properly assess the disparate impacts on children and youth of color who run away from care. The CDHS confirmed Trails has the ability to capture demographic information and placement history. However, without robust data regarding the experiences of children and youth – both in why they ran away from care and what happened while they were gone – there is no way to fully account for and address systemic disparities.

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.

## Recommendations for Directive One

**“Analyze the sufficiency of statewide data that measures the quantitative and qualitative experiences of children who have run away from out-of-home placement.” (C.R.S. §19-3.3-111(5)(a))**

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement has two recommendations regarding improving the sufficiency of quantitative and qualitative statewide data regarding the experiences of children who have run away from care:

### Recommendation 1(A): Creation of a Standard, Statewide Information and Data Collection System

The Colorado General Assembly should propose and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to develop a standard, statewide information and data collection system (data system). This data system should collect information regarding children and youth who run away from care (as addressed in Recommendation 6(C)). The legislation should implement the developed data system and require its use by providers, county departments of human services and the Colorado Department of Human Services. Finally, the standard, statewide data system should be evaluated every two years.

All information and data gathered from children or youth should be done in a trauma-informed manner. This information and data must include, at a minimum, the following:

- » The conditions that contributed to a child or youth running from care, including reasons self-reported by children or youth;
- » The experiences of children and youth while they were away from care;
- » The services and care provided to children and youth after they returned to care;
- » Data concerning the number of incidents of children and youth who have run away from care;
- » Data concerning the number of children or youth who ran away from care multiple times;





- » Data concerning the number of children or youth whose placement changed subsequent to their running away from care;
- » Data concerning the placement of children and youth who were recovered after running away from care;
- » Data demonstrating the duration children or youth were away from care; and
- » Data demonstrating the number of times physical restraints were used in an attempt to prevent a child or youth from running away from care.

The standard, statewide data system should accommodate the collection and storage of information and data from across Colorado. In assessing the placement and operations of this standard, statewide data system, the third-party consultant should consider utilization of the current statewide child welfare database, Trails. If Trails is unable to accommodate the components listed below, an alternative system that is compatible with Trails should be developed.

**The data system should also allow for the following functionalities:**

- » Any needed updates to the high-risk victimization tool or similar evaluations;
- » Protections to ensure the data system does not artificially limit the amount of information that may be entered;
- » Timelines for when the data and information should be collected from the child or youth and

the deadline for when data and information should be entered into the data system. The task force recommends that information be collected no more than 24 hours after a child or youth returns to care and entered into the standard data system no more than 48 hours after their return;

- » Ensure the data system allows for the collection of demographic information of children and youth who run away from care, when available. This demographic data must include, if available, but is not limited to: race, ethnicity, language, gender expression, disability status, sexual orientation, national origin, and income;<sup>27</sup> and
- » Ensure the data system allows for the extraction of data and information that is comprehensive and allows for meaningful analysis.

Lastly, for any statewide, standard data system to be effective, the third-party consultant or institution of higher education must ensure the data system includes the ongoing use of focus groups of children and youth in out-of-home placements and providers. Such research shall be completed to remain current on what conditions or reasons cause children or youth to run away from care, the provider's efforts to locate children or youth who have run away, and the services provided after returning to care. There should also be publication of an annual report detailing data and information contained in the data system. This report must be proactively published and made available to the public and ensure a copy is provided to the General Assembly.

<sup>30</sup> Such demographic information should be congruent with the collection of demographic information required under [Senate Bill 24-200](#).

## Recommendation 1(B): Development of Standard Training for the Standard, Statewide Information and Data Collection System

The third-party consultant or institution of higher education should also be funded to, and charged with, developing standard and required training for those required to collect, enter and/or analyze data or information required by the data system proposed in Recommendation 1(A). The legislation should implement the developed training and require completion of the training by providers, county departments of human services and the Colorado

Department of Human Services. Finally, the standard, statewide training should be evaluated every two years.

### The curriculum should, at a minimum, include training on the following:

- » The collection of the data and information outlined above;
- » The entry of data and information into the standard data system; and
- » Implicit bias in the collection and analysis of data.

## DIRECTIVE TWO

### Analyze the root cause of why children and youth run away from care.

The question posed in Directive Two permeated throughout the duration of the task force. Consideration of each directive – in some form – related back to why children and youth run away from care. These discussions are summarized throughout this report. It should be noted that all task force members acknowledged the importance of understanding children and youth’s reasons for running. HB 22-1375 contemplated these issues and addressed them by requiring the commission of a report by an institution of higher education. The Colorado Evaluation and Action Lab was selected to complete this task.

The Lab’s final report – *Strengthening Connections: Youth and Provider Perspectives on Youth Running from Out-of-Home Placements* – was provided to the task force in the spring of 2023. This report provided task force members with a snapshot of the perspectives and experiences of children and youth residing in residential facilities. Ultimately, participants in the focus groups identified three conditions that cause children and youth to run away from care:

- 1. Running from the placement due to dysregulation from triggering events, disconnection from staff and responses to previous trauma.** Youth participants discussed feeling as though they were in a state of emergency when they ran away from care. The youth stated that this feeling interfered with their ability to consider the risks and consequences of running away from care. Youth reported that they often enter this headspace after a “triggering event” that can include a phone call with a family member or something that reminds them they are “missing out” on events while at the facility. Feeling unsafe or disconnected from staff members may also cause youth to feel dysregulated, as well as when youth perceive dangers that resemble past traumatic experiences.
- 2. Running to connectedness and familiarity.** Youth stated that they feel disconnected from family, friends and experiences while they are in residential care. They stated a strong desire to remain connected to family and friends and to remain connected to familiar environments or places. This desire to feel connected is often a reason for running away from care.
- 3. Running due to typical adolescent behavior.** The report also captures responses from youth participants that demonstrated normal behaviors for developing adolescents. This included the desire to test boundaries, explore the world around them and to have autonomy over their own lives.

This desire to feel connected is often a reason for running away from care.

Members generally agreed that the report is a valuable resource for understanding the issue of children and youth running away from care. Their discussions of the report spawned additional ideas regarding how data collection processes may 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 children and youth who run away from care.

## Response to Directive Two

“Analyze the root causes of why children run away from out-of-home placement.” (C.R.S. §19-3.3-111(5)(b))

### DIRECTIVE THREE

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.

Task force members agreed that every instance of a child or youth running away from care warrants a response and consideration of the risks the child or youth will face. However, the nature of that response should vary depending on the unique characteristics of each child or youth. This is because certain characteristics inherently place a child or youth at an elevated level of risk that should prompt varying responses from professionals. These characteristics are distinct from circumstances in which a child or youth running away does not present a high risk to their safety or well-being and/or demonstrate age-appropriate behaviors.

Despite national recognition that children and youth who run away from care face increased risks of victimization to crimes and trafficking, Colorado law does not require any entity in the state to actively locate children or youth who run in these circumstances. This stands in contrast to other states that have worked to standardize and improve how they respond to children and youth who run away from care.<sup>28</sup> The CPO conducted a 50-state statutory

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement completed the required analysis under C.R.S. 19-3.3-111(5)(b). This was done through multiple discussions by members throughout the duration of the task force. It was also achieved with the completion and publication of the report capturing experiences of children and youth in residential care, as well as providers, required under C.R.S. 19-3.3-111(6)(a). As such, the task force is not issuing a recommendation specific to Directive Two.

However, members of the task force identified the benefits of the regular collection and dissemination of this information. To accomplish this, the task force has incorporated the required collection and publication of such information within the components of Recommendation 1(A).



<sup>28</sup> See [Developing a System Response to Youth Who Run from Out-of-Home Placements](#).



and regulatory analysis and found several examples of jurisdictions that have developed standard criteria for determining a child or youth's risk for running away from care and standard protocols for responding to and locating children and youth after they have run.<sup>29</sup>

Using this information, the task force worked to establish standard characteristics that inherently place a child or youth at an elevated risk to their safety or well-being. When a child or youth runs away from care – and one or more of these characteristics are present – the task force determined that professionals should initiate a standard response. Ultimately, based on these standard characteristics, the task force identified the need for the development of two standard, statewide systems:

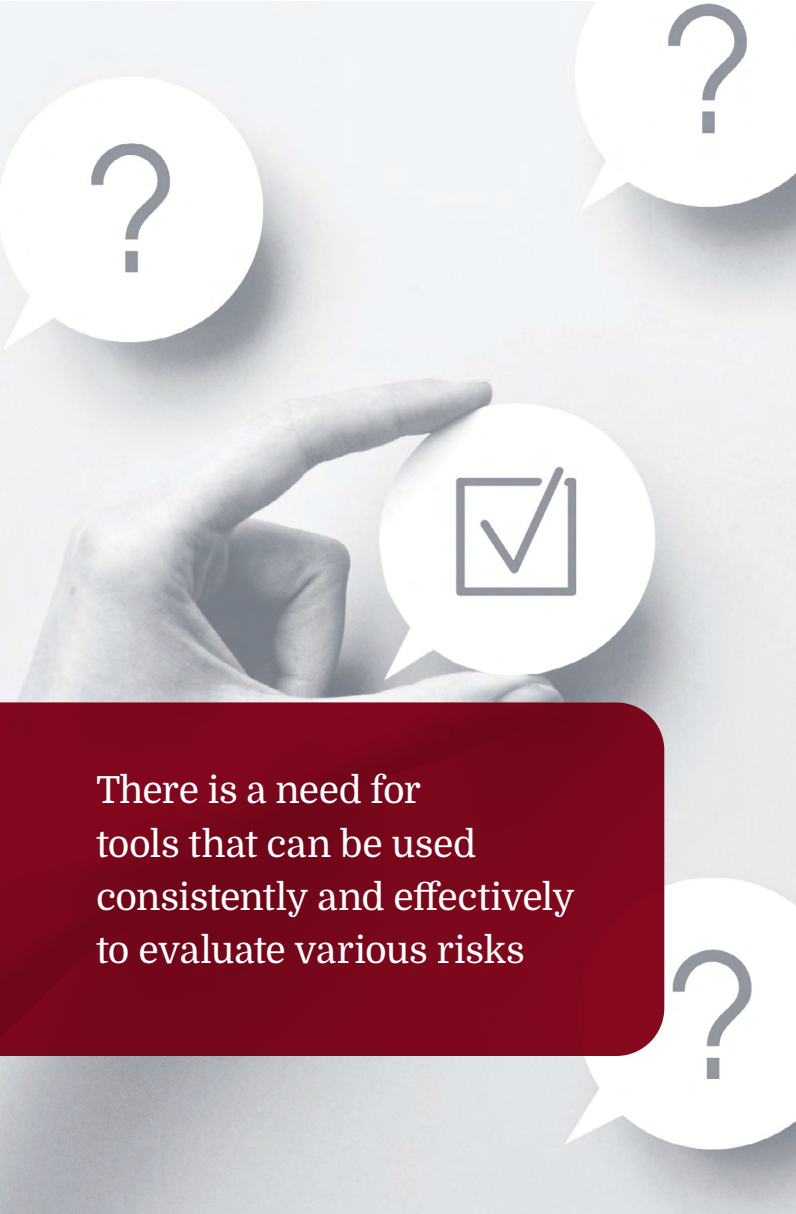
1. **A standard, statewide assessment** that utilizes multi-tiered categories to designate a child or youth's risk level associated with running away from care.
2. **A system that utilizes the determinations** discussed above to develop statewide, standard response protocols.

The majority of members agreed developing risk categories could help to improve efforts to prevent children and youth from running away from care. However, several members cautioned that objective and consistent criteria are necessary for determining appropriate levels of risk and interventions. The subjective nature of determining the individual risk of children and youth can vary depending on the professional performing the assessment.

The task force also highlighted the need to ensure that response times for certain cases are not artificially delayed based on a child or youth's categorization. Additional considerations for implementing multi-tiered categories include:

- » Conducting a risk assessment upon intake is crucial to properly start assessing risk.
- » Assessments should be completed and evaluated at a therapeutic level beforehand to avoid leaving the decision to individual staff to determine an immediate and appropriate response to a runaway incident.
- » Ongoing data collection and preparation are necessary to ensure that information is readily available and current.
- » Information sharing between placements is crucial for children and youth in care, but obtaining and transferring information effectively poses a challenge – there is no standardized system for sharing information as children move through facilities.

Members also acknowledged challenges in assessing a child or youth's risk when professionals minimize reported risks. Such limitations exist with the use of current tools, such as the HRV tool, which rely on limited information and may be impacted by a lack of engagement by the child or youth. There is a need for tools that can be used consistently and effectively to evaluate various risks, including suicidal ideation, medical needs and susceptibility to exploitation.



There is a need for tools that can be used consistently and effectively to evaluate various risks



Crucial to the success of the multi-tiered categories of risk, the majority of members found, was the development of correlating, standard response protocols for each category of risk. Based on the risk level determined for each child or youth, different response protocols should be used. For instance, if it is determined that the child or youth will engage in self-harming behaviors after running from care, their running from care would prompt certain response requirements not shared with those children and youth who have been determined to face fewer risks while on the run. The child or youth's risk designation would impact response components such as: timeframes, involvement of other agencies/entities, notifications, recovery efforts and reporting practices.

### **Recommendations for Directive Three**

**“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.”**  
(C.R.S. § 19-3.3-111(5)(c))

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement has three recommendations to develop standardized statewide policies regarding how to respond to and care for children and youth who run away from care.

### **Recommendation 3(A): Define Risk Categories for Children or Youth Who Run away from Care**

The task force was unable to create a singular definition for what constitutes running away from care. Members did agree each incident of a child or youth running away from care warrants some level of response. However, the nature of that response should vary depending on the unique characteristics for each child or youth. This is because certain characteristics inherently place a child or youth at an elevated level of risk that should prompt varying responses from professionals. These characteristics are distinct from circumstances in which a child or youth running away does not present a high risk to their safety or well-being and/or demonstrate age-appropriate behaviors. The characteristics that present an elevated level of risk are:

- » The child or youth is believed to be in the company of adults who could endanger their safety;
- » The child or youth has exhibited suicidal tendencies, or expressed suicidal ideation;
- » The child or youth is believed to have intent to severely physically harm another person;
- » The child or youth is 11 years of age or younger and/or is believed to be out of the zone of safety for their age or developmental stage;
- » The child or youth has one or more health conditions that, if not treated daily, will place the child or youth at severe risk;



- » The child or youth is drug dependent, including prescribed medication and/or illegal substances, and the dependency could be a danger to self or others;
- » The child or youth has severe emotional problems that, if not treated, will place the child or youth at severe risk;
- » The child or youth has a developmental disability that impairs the child or youth's ability to care for themself;
- » The child or youth is pregnant or parenting;
- » The child or youth is missing more than 24 hours before being reported to law enforcement;
- » The child or youth is believed to be in a life-threatening situation;
- » The child or youth's absence is inconsistent with their established patterns of behavior and the deviation is not readily explained;
- » The child or youth is known or believed to be a victim of human trafficking (sex trafficking, labor trafficking, or both); and/or
- » Other circumstances that would cause a reasonable person to conclude that the child or youth should be considered at imminent risk.

Based on the characteristics stated above, the Colorado General Assembly should propose and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to develop statewide, standardized multi-tiered categories of risk, designating a child or youth's risk level associated with running away from care. The legislation should implement the statewide, standardized multi-tiered categories of risk and require use of the categories by providers, county departments of human services and the Colorado Department of Human Services. Finally, the standard, statewide categories of risk should be evaluated every two years.

The third-party consultant or institution of higher education should determine how a child or youth will receive a designation in a particular category of risk at the beginning of their placement. This process must include the consideration of any protective factors present when the child or youth ran away from

care, including whether they took a cell phone with them or returned to a safe location. This designation may be reconsidered and re-evaluated periodically as conditions for the child or youth may change. This designation must be reconsidered and re-evaluated following each incident of a child or youth running away from care. A child or youth's designation in a particular category of risk will then determine how and when various entities should respond if the child or youth were to run from care (as described in Recommendation 3(B)).

### **Recommendation 3(B): Utilizing Defined Risk Categories, Develop Standard Response Protocols for Children or Youth Who Run Away from Care**

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The Colorado General Assembly should propose and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to create statewide, standard response protocols. The legislation should implement the statewide, standard response protocols and require use of the response protocols by providers, county departments of human services and the Colorado Department of Human Services. Finally, the standard, statewide response protocols should be evaluated every two years.

If a child or youth runs from care, the risk category they have been attributed (see Recommendation 3(A)) should be utilized to trigger specific types of required response protocols. The child or youth's risk designation would impact response components such as: timeframes, involvement of specialized investigation staff (see Recommendation 7(A)) and other agencies/entities, notifications, recovery efforts, and reporting practices.

### **Recommendation 3(C): Ensure Diversity, Equity and Inclusion are Considered**

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In developing the multi-tiered risk criteria and standard response protocols, the third-party consultant or institution of higher education should ensure that both products consider the race, ethnicity, language, gender expression, disability status, sexual orientation, national origin and income of the child or youth.<sup>30</sup> This information will be used to assess and monitor the response to children and youth who run away from care for any disparate impacts or practices.

## DIRECTIVE FOUR

### 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.

For more than a decade, national research and statistics have shown that children and youth who run away from out-of-home placements are at greater risk of experiencing harm – including the risk of substance use and trafficking.<sup>31</sup> According to a 2020 report from the U.S. Department of Health and Human Services, youth who have run away from foster care are more likely to experience academic underperformance, involvement with the juvenile justice system and an increased vulnerability to sexual victimization and trafficking.<sup>32</sup> Running away from care was found to be the most common pathway to sex trafficking victimization. Based

**Currently, there is only a requirement that professionals inquire as to whether a child or youth was a possible sex trafficking victim.**

on data available at the time the report was published, it was estimated that 19 percent of children and youth who run away from foster care are assessed to be likely victims of sex trafficking.

Colorado does not employ a standard, statewide system of tracking the experiences of children and youth who run away from care. As stated above, there is minimal research in this area concerning cases in Colorado. The limited information available demonstrates that any child or youth who runs away from home faces a risk of being exploited.<sup>33</sup> Currently, there is only a requirement that professionals inquire as to whether a child or youth was a possible sex trafficking victim. There are no statewide, standard inquiries into whether the child was the victim of other criminal activity, engaged in substance use or was the victim of sexual violence by a peer – all situations which have been previously reported by children or youth after running away from care. Many providers utilize the HRV tool as a consistent means of evaluating a child or youth’s possible exposure to sex trafficking. However, providers themselves recognize the deficit of this tool because it is not implemented consistently nor is there any standard, required training on how to use the tool.

Without any meaningful study or comprehensive data, professionals working in this field repeatedly rely on anecdotal evidence to drive policy decisions. This was evident even among task force members as they discussed the dangers facing children and youth who run away from care in Colorado. While there was disagreement regarding the perceived experiences of children and youth while they are away from care, task force members agreed that they do not have the necessary information to address this directive.

### Response to Directive Four

**“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.” (C.R.S. §19-3.3-111(5)(d))**

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement completed the analysis required under C.R.S. 19-3.3-111(5)(d). Ultimately, the task force found that, currently, there is not sufficient data and information in Colorado to determine the relationship articulated in Directive Four. As such, the task force is unable to issue a recommendation. To address this gap, the task force has proposed the statewide, standard data system detailed in Recommendation 1(A).

<sup>31</sup> See Office of Inspector General, U.S. Department of Health and Human Services (2022). [National Snapshot of State Agency Approaches to Reporting and Locating Children Missing from Foster Care](#). A-07-20-06095.

<sup>32</sup> See Latzman, N. E., & Gibbs, D. (2020). [Examining the link: Foster care runaway episodes and human trafficking](#). OPRE Report No. 2020-143. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

<sup>33</sup> See Colorado Bureau of Investigation (2022). [Missing Children Report 2021: Annual Report](#).



## DIRECTIVE FIVE

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.

To address Directive Five, task force discussions focused on three main areas: (1) Needed clarity regarding when facility staff have a duty to intervene when a child or youth threatens or attempts to run away from care; (2) Notification to parents of facilities' intervention policies and (3) Short-term stabilization units for children and youth after they return from running away from care. Each is discussed in detail below.

### Clarifying the Law

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Discussions surrounding a facility's ability to stop a child or youth from running away was one of the most anticipated and complex conversations for members. This is largely because the majority of members found that current Colorado law is unclear and does not provide effective guidance for facilities regarding what they are permitted to do to prevent a child or youth from running away. This includes the question of whether facility staff may ever physically stop a child or youth from running. Due to this ambiguity, it was clear that anecdotes and long-time practices – instead of clear legal interpretations – were dictating how professionals in the field were addressing the issue. As such, the majority of the task force sought to add clarity to the law by addressing a facility's responsibility to intervene, what information parents and caregivers must be provided regarding a facility's restraint policy and addressing facilities' liability in implementing intervention practices.

### Responsibility to Intervene

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While task force members were not in consensus regarding the sufficiency of current law, the majority of members agreed there is no clear guidance regarding a facility's responsibility to stop a child or youth from running away from care, nor is there any clear guidance regarding what intervention methods may be appropriate to do so. Members discussed how this lack of clarity and training has led to inconsistent enforcement of licensing standards. As a result, some facilities are cited for licensing violations when they attempt to stop a child or youth from leaving the facility, while others are not.

In particular, members discussed the need for law to clarify when providers have a responsibility to intervene and stop a child or youth from running away from care. Specifically, providers cited incidents when a child or youth's history is known to providers and demonstrates



a clear pattern of dangerous behaviors while on the run. Such behaviors may include a history of attempts to harm others or themselves, previous experiences of being a victim of a crime or a history of engaging in inherently risky behavior – such as running into traffic. A child or youth’s intellectual, mental or behavioral health should also be considered and weighed when determining whether a facility has a responsibility to intervene and stop a child or youth from running away from care. This clarification would allow providers to intervene when an immediate threat is not present, but a substantial risk of harm is known. The majority of task force members also agreed that providing such clarity in law would be more successful if paired with the proposed risk criteria in Recommendation 3(A) and the proposed pre-admission and recovery screening tools discussed in Recommendation 6(C).

**Implementing measures like a good faith requirement can help provide clarity and protection. Such measures can mitigate risks and ensure the actions are taken in the best interest of children and youth.**

### **Creating a Good Faith Standard**

Equally important to the notion of clarifying the responsibility to intervene is the need to establish – in law – a good faith standard. This standard would allow facilities and providers to make decisions regarding a child and youth’s care based on their understanding of the child/youth’s background and care needs. Implementing measures like a good faith requirement can help provide clarity and protection. Such measures can mitigate risks and ensure the actions are taken in the best interest of children and youth. The majority of members also agreed that clear and consistent documentation standards are key for the proper implementation of a good faith provision. These standards should be set in statute.

### **Notification of Parents and Caregivers**

Of equal importance, it was determined that there is no requirement that parents and caregivers are informed of facility intervention policies. As a result, parents and caregivers often have inaccurate expectations regarding what staff should do to stop their children from running. In many cases, this

results in parents and caregivers being unaware that many providers will not utilize physical restraints to stop their children – even if the child or youth has a history of running and engaging in dangerous activities. Additionally, two members of the task force – each of whom had experience with their own children running away from facilities – stated there were several instances in which they wish staff had physically stopped their children from running. Both agreed that part of the decision on whether to use physical restraints should consider the wishes of a parent or caregiver. As such, the task force discussed the creation of a standard, statewide waiver that may be used in facilities. Parents and caregivers should be provided with the waiver, informed of practices and then able to decide if they feel physical restraints are appropriate for their child.

### **Short-term Stabilization Units**

After a child or youth runs away from care, their return to their original placement is not always guaranteed. Task force members noted that in some circumstances, the act of running away from care can cause a child or youth to lose their placement, or the placement may no longer be a safe or appropriate space for them to return to. Many members stated that, currently, there is no unique space for children and youth in this circumstance to recover after running away from care. As a result, many of these children and youth are housed in alternative, temporary placements that do not meet their treatment needs, and, in some cases, do not meet their physical safety needs. For example, if a child or youth loses their placement as a result of running away from care, they may be forced to enter a hospital that is too restrictive for their needs. Or, if no other option is available, they may be forced to reside in a hotel without treatment while a new placement is found. In any case, the inconsistent practice of housing children and youth in this circumstance has effectively prevented many from receiving sufficient assessment and care.

The task force discussed the need to establish short-term stabilization units. These units would be specifically designed to serve this population and provide consistent intensive clinical and behavioral support for children and youth after they are found or return from running away. While there was general consensus concerning this gap in services, many members expressed caution in developing parameters around these units. Such units may be able to provide a much-needed role in providing a continuum of care for a child or youth who runs away from care. Many members emphasized the need for these units to provide assessment and care for substance use and behavioral health. However, members advised that they should not be utilized as alternative, long-term placement options. Stays at units similar to the ones envisioned by the task force present inevitable interruptions to education, therapies, mental and behavioral health care and, in some cases, medical care. As such, members were adamant that any units developed must be designed to provide short-term stabilization and have the ability to effectively share information about children and youth who pass through.

## Recommendations for Directive Five

**“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.” (C.R.S. §19-3.3-111(5)(e))**

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement has five recommendations regarding clarifying Colorado law, the use of physical restraints and the development of temporary placement facilities.

### Recommendation 5(A): Clarify the meaning of “imminent”

Colorado General Assembly should amend Colorado statute to clarify the term “imminent” within C.R.S. 26-20-102(3). Such an amendment should seek to codify the broader interpretations of imminent found in current case law.

## The task force proposes the following amendment:

### C.R.S. §26-20-102

(3) *“Emergency” means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.*

(4) *“IMMINENT” MEANS AN IMPENDING THREAT TO ONE’S SAFETY THAT MAY NOT BE ABSOLUTE OR IMMEDIATE, BUT THE NATURE OF THE THREAT IS SEVERE.*

### Recommendation 5(B): Clarify a facility’s duty to intervene

The Colorado General Assembly amend Colorado statute to clarify when facilities have a duty to intervene when a child or youth threatens or attempts to run away from care. This amendment should make clear, based on criteria and standard protocols detailed in Recommendations 3(A) and 3(B), the continuum of methods that are available to facilities to prevent a child or youth from running away from care.

### Recommendation 5(C): Establish a “Good Faith” Provision for Facilities Regarding the Use of Restraints

The Colorado General Assembly amend Colorado statute to create a “good faith” provision regarding the duty of facilities to respond when a child or youth threatens or attempts to run away from care.

### Recommendation 5(D): Require Parents and Caregivers be Informed of Policies

The Colorado General Assembly should amend Colorado statute to require facilities and providers provide parents and caregivers with their individual policies regarding the use of physical restraints. The legislation should also require the development and implementation of a waiver parents or caregivers may sign, allowing the use of physical restraints to stop their child or youth from running away from care, when applicable. This information should also be collected and published by the Colorado Department of Human Services, which should be charged with ensuring the information is accurate and meets legal requirements.

## Recommendation 5(E): Develop Proposal for Short-Term Stabilization Units

The Colorado General Assembly should propose and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to develop a plan for the creation and implementation of short-term stabilization units (STSUs) for children and youth after they run away from care. Services provided by the STSUs are intended to aid children and youth who have run away from care multiple times. These STSUs would be established to provide intensive clinical and behavioral support for children or youth that have run away from care and who may

have behavioral, or substance use concerns. The STSUs would provide a comprehensive assessment and develop a plan to return the child or youth to their original placement location, or to enter into a new long-term placement arrangement. The proposal would also include follow-up engagements with the child or youth, personnel at the new placement if applicable and other involved parties to support any transition. The selected third-party consultant or institution of higher education should develop a public-facing plan detailing key components of the STSUs.

### **As part of this analysis, the third-party consultant or institution of higher education should consider the task force's desire that such placements contemplate the following:**

- » Ensure that the proposal is permissible under federal and state law.
- » STSUs should not be mere holding places but should include programming to identify and meet the clinical needs of children or youth. This includes continuity in education and service or treatment plans established before they run.
- » The plan should specify the maximum amount of time a child or youth may spend in the STSU. This duration should contemplate requirements under federal and state law, and ensure that children and youth move through the STSU.
- » The proposal must define how children or youth will continue with components including, but not limited to, education, therapy (if applicable) and contact with family, caregivers and/or care team.
- » The proposal must specify how STSUs would care for children or youth who present as under the influence of substances at intake.
- » There should be effective communication and collaboration across various disciplines and entities involved with the child or youth to ensure cohesive support.
- » Upon intake, there should be an assessment to understand the root causes of the child or youth running away from care and to inform longer-term placement planning.
- » STSUs should ensure that children or youth who are on medication continue to receive them, addressing liability concerns.
- » STSU facilities should emphasize stabilization, safety planning and permanency planning as integral parts of the STSU process.
- » STSU facilities should take into account the developmental stage and any intellectual or developmental disabilities of the child or youth.
- » STSU facilities should address gaps in data to better understand the scope of the issue and inform further planning efforts. They should also embed requirements for data collection and use.
- » STSU systems and policies should ensure that STSUs meet the culturally relevant needs of children or youth and that there is consistency in options available for both temporary and longer-term placements.




**DIRECTIVE SIX**

Analyze best practices at both the statewide and national levels for preventing and addressing runaway behavior, including methods to discourage children from running away.

The CPO provided the task force with substantial research regarding the statute, regulations and practice guiding other states working to address children and youth who run away from care. Based on that research and the conversations of the task force, the majority of members felt it appropriate to focus their analysis on the following four areas:

- 1. Considerations of the physical infrastructure** of facilities.
- 2. Development of a pre-admission risk assessment tool** to consider a child or youth's likelihood of running and correlating risks.
- 3. Development of a post-run recovery screening tool** to help assess the mental and physical safety of children and youth after they run away from care.
- 4. Education of children, youth and caregivers** concerning the risks associated with running away from care.

### Physical Infrastructure of Residential Facilities

The majority of residential facilities in Colorado are not locked campuses. This means there are no locked gates or doors that prevent children or youth from running off the campus at any time. While there were some members of the task force that felt all facilities should be secured – which would prevent children and youth from running – the majority of members approached the issue with

a different perspective. The majority of members agreed that additional considerations of the physical infrastructure of facilities would be appropriate. This included alarms, fencing, delayed egress and delayed locks. It should be noted that members did not discuss additional physical infrastructure for foster care placements. Generally, task force members agreed that the implementation of many of the methods would not be possible in foster care environments given the diverse needs of children and youth in foster home placements and the large volume of foster homes located throughout the state.

Task force members expressed general agreement that additional physical infrastructure should be considered. However, members were also extremely cautious about implementing too many security measures and eroding a provider's ability to ensure therapeutic services are properly delivered. There was broad agreement that residential facilities should not emulate the secured facilities used in the juvenile justice system. This is particularly true if different facilities implement different levels of security. It is imperative that children and youth of color are not disproportionately impacted by implemented security measures.

Members explicitly considered the following security measures as potential ways to prevent children and youth from running away from care. Additional cameras, ankle monitors and lighting were also addressed.

## **Delayed Egress**

Members discussed that delayed egress doors may not effectively prevent determined children and youth from running away. Facilities that implement delayed egress doors have doors that have a delay mechanism. That mechanism triggers an alarm when pushed, preventing immediate opening for a set period of time, typically around 30 seconds. Members emphasized that the use of these delayed doors must be in compliance with fire safety codes and concerns. Overall, there was general agreement among members to explore the use of delayed egress doors as a preventative measure, with the understanding that further research and considerations about specific implementation may be necessary.

## **Alarms**

The task force also considered the use of additional alarms as a less expensive prevention method. Specifically, members discussed the use of alarms that would quietly alert staff when a child or youth leaves their room. These alarms could also be used to alert staff when children or youth breach the boundary of an unsecured campus.

## **Fencing**

Reiterating concerns above, members agreed that residential facilities should not resemble jails or prisons and should remain inviting for children or youth. The task force agreed that there must be a balance between individual rights and security. However, the task force also noted that perimeter security is essential for keeping dangers out. There was unanimous agreement that fencing could be an effective method for preventing children and youth from running away from care.

## **Motion Detectors**

Use of infrared, motion sensing alarms was also discussed. Members acknowledge the benefits of staff being alerted when children or youth walk out of their rooms at night, or a different boundary is breached. This was also presented as a way to support facilities working with minimal staff.

## **Signage and Lighting**

Improving the signage and lighting around facilities was discussed as a way to improve the safety of

children and youth who may run from the facility, as well as the surrounding community. For example, members discussed how posting signs near facilities in high traffic areas to watch for children and youth, and improving lighting, could help prevent children and youth from being hit after running away from care.

Ultimately, 80 percent of members who responded to a survey agreed that Colorado should pursue additional analysis regarding the implementation of additional physical hardware to prevent children and youth from running away from care. The majority of the task force agreed that this information was critical to determine what equipment would be beneficial, and what funding would be necessary to implement such changes. Finally, there was consensus among members that the presence of physical infrastructure should not be seen as a substitute for adequate staffing.

## **Development of Pre-Admission and Post-Run Recovery Screening Tools to Consider a Child or Youth's Likelihood of Running and Correlating Risks.**

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Similar to the task force discussions concerning the need for standard risk criteria, members also identified the benefits of a standard pre-admission screening tool, as well as a post-run recovery screening tool. Currently, there is no standard, statewide assessment completed when a child or youth enters a residential facility for care. Different facilities may implement different processes when admitting a child or youth – not all of which comport with the other. Without a standard screening tool – and training on how to administer it – task force members identified a continuity issue with care. Namely, facilities may not be aware of a child or youth's history of running away from care. This could include information regarding past reasons the child or youth stated they ran away from care, where they went and what experiences they had while they were gone.

This gap has been previously noted in this report. However, when responding to this directive, task force members recognized that implementing a standardized pre-admission screening tool could help providers determine the appropriate level of intervention when a youth or child is threatening to run away or appears on the verge of doing so. These screening tools could be used to create individualized

response plans for children or youth who run away from care. For example, if a child or youth has a history of running away from care and engaging in dangerous behaviors while away, this may cause providers to intervene sooner or with different methods.

Members were cautious, however, to ensure that information gathered as part of any pre-admission screening could not be used to exclude or prevent the child or youth from accessing care. Anecdotally, several members mentioned instances in which a child or youth may be turned away from a residential facility due to a history of chronic running or self-harm. One member emphasized that state law prohibits treatment plans that include the prescribed use of restraints. However, the task force was careful to note that the use of restraints to prevent a child or youth from running would not meet the standard of use prohibited in law. The majority of members stated that the use of a pre-admission tool and standard response protocols would not constitute a treatment plan.

### Education Regarding the Risks of Running Away from Care

Currently, Colorado has no standard or required training or education curriculum for children, youth or their families regarding the risks of running away from care. If any training is provided to these individuals, it varies depending on who is providing the training and when it is provided. Education about the risks of running from care may be substantially different after a child or youth is recovered from a run, as opposed to providing it prior to their first run. Additionally, there is no standard or required education on the risks of running from care for foster parents in Colorado.

The task force was provided with research regarding national models and programs working to enhance support and safety measurements for children and youth. The task force spent a substantial amount of time considering the resources offered by the

National Runaway Safeline (NRS). NRS operates the 1-800-RUNAWAY hotline and provides online chat, email, text, and message board services. Specifically, members discussed the curriculum and materials developed by NRS that address the risks of running away from care. They provide a program called Home Free in collaboration with Greyhound, offering free bus tickets for children and youth returning home. Data from NRS shows that children and youth in Colorado have already utilized these services. This includes children and youth accessing information about the risks of running away from care, and other resources provided by NRS.

Colorado-specific statistics from 2022 show that most children and youth contact NRS via live chat, with significant numbers considering running away due to family dynamics and abuse. Demographics indicate a majority of contacts are female, with a notable age distribution towards older youth. There was discussion about the potential for integrating

NRS curriculum into regular practices, especially in out-of-home placements where children and youth have a higher risk of running away.

Many members of the group acknowledged the potential positive impact of the program in foster care and residential settings. Members also heard from a group of panelists representing foster parents and their experiences with children and youth who run away from care.<sup>34</sup> The discussion centered on developing a better understanding of how to better support foster care providers and improve systems for addressing when children and youth run away from foster placements. Foster parents have minimal training regarding how to prevent a child or youth from running away from their care. Similarly, foster parents stated that they do not have adequate support for after a runaway incident occurs and are unsure of how to help locate a child or youth. When a child or youth runs away, it often happens during evenings or weekends, times when support is typically less accessible. Call centers, which foster parents rely on during such crises, may not be equipped or trained to provide adequate guidance.

**Currently, Colorado has no standard or required training or education curriculum for children, youth or their families regarding the risks of running away from care.**

<sup>34</sup> Panelists included Stacey Sanders, Executive Director, Elevating Connections Inc.; Jenna Coleman, Executive Director, Specialized Alternatives for Families and Youth; and Renee Bernhard, Executive Director, Foster Source.



## Recommendations for Directive Six

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“Analyze the 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.” (C.R.S. §19-3.3-111(5)(f))

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement has five recommendations on the following topics: (1) Improvements to the physical infrastructure of facilities to help reduce the number of children and youth who run away from care; (2) Development of a pre-admission screening tool to help determine a child or youth’s risk of running away and an individualized response plan; (3) Development of a post-run recovery screening tool; and (4) Developing standard and required training regarding the risks of running away from care.

### Recommendation 6(A): Additional Assessment of Physical Infrastructure Needs

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The Colorado General Assembly should fund a statewide assessment of additional physical infrastructure within residential facilities to help prevent children and youth from running from out-of-home care. This study should include the use of delayed locks, fencing and alarms. Funding should also be provided for the implementation of these mechanisms, if the study finds their use to be appropriate.

### Recommendation 6(B): Require Consideration of a Placement’s Physical Infrastructure

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The task force recognizes that children and youth in residential facilities are deserving of supportive, trauma-informed environments. The task force also recognizes that this must be balanced with measures to ensure children and youth are secure and safe. As such, the following recommendation should be done in the least restrictive way.

The task force recommends the promulgation of statute or regulations to require children or youth be assessed prior to placement in facilities, to ensure the facility’s physical infrastructure is congruent with the needs of the child or youth. This evaluation



should be done in a manner that places consideration of a facility’s physical infrastructure in balance with other considerations of any clinical assessment. This placement should be regularly reviewed to determine if a less restrictive environment is available and adequate.

### Recommendation 6(C): Develop a Standard Pre-Admission Risk Assessment Tool and a Post-Run Recovery Screening Tool

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The Colorado General Assembly should draft and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to develop a pre-admission risk assessment tool that is utilized shortly after a child or youth has been placed in out-of-home care. The third-party consultant or institution of higher education should also develop a standard, statewide post-run recovery screening tool to be utilized shortly after a child or youth who has run away from care returns or is recovered.

Use of the tools should be required for children or youth placed in residential facilities, or children or youth in a foster care placement, if the child or youth has a history of running away from care.

The third-party consultant or institution of higher education should also develop a one-year pilot program utilizing the running risk assessment screening tool and standard data system described in Recommendation 1(A). The pilot program should include both urban and rural counties.

In developing the pre-admission tool and the pilot program, the third-party consultant or institution of higher education should incorporate the following:

- » Evaluation methods throughout and after the pilot program, and enabling tool modifications based on evaluation and feedback in order to ensure an optimal program to potentially be implemented statewide after the pilot period.
- » Creation and implementation of standard training for those who will utilize the screening tools.
- » Development of practices for monitoring compliance with the requirements of the tools and related data entry.
- » Incorporation of trauma-informed practices throughout the development and implementation of the tools.
- » Determination of how the information obtained from the tools may be used to adjust a treatment plan for the child or youth while they are in out-of-home care. This should include possible interventions for a child or youth threatening or attempting to run away from care.

In developing the post-run recovery screening tool and the pilot program, the third-party consultant or institution of higher education should incorporate the following:

- » Determine appropriate timelines for required assessments of children or youth upon their recovery or return.
- » Statewide, standard practices for promptly referring children and youth to receive medical care and assessment.

- » Standard and required assessments of a child or youth's physical and mental health and any pain or substance use, if applicable.
- » Requirement that the High-Risk Victimization tool and other information outlined in Recommendation 1(A) is collected in a timely manner.

In developing the tools and pilot programs, the third-party consultant should require that information collected by the tools be entered into the data system recommended in Recommendation 1(A) to ensure the information is available statewide. Additionally, the development of the tools and pilot programs should utilize the characteristics of a child or youth running away from care, as stated in Recommendation 3(A).

### **Recommendation 6(D): Create Standard Education for Those Providing Out-of-Home Care**

The Colorado General Assembly should propose and fund legislation to create standard and required education for those providing out-of-home care to children and youth, including residential facilities and foster care providers regarding the risks of running away from care. This education should consider programs such as the National Runaway Safeline and others studied by the task force. Any education curriculums for providers should be made public and provided to parents and caregivers of children and youth residing in out-of-home care.

The curriculums for providers should also include components of implicit bias and be cognizant of the race, ethnicity, language, gender expression, disability status, sexual orientation, national origin, and income of the children and youth in care.<sup>35</sup> Statute should require the regular review and revision of such training and provide opportunities for public feedback.



## Recommendation 6(E): Create Standard Education for Children/Youth Regarding the Risks of Running Away from Care

The Colorado General Assembly should propose and fund legislation to create standard and required education for children and youth residing in out-of-home care, regarding the risks of running away from care. The recommended education should only be required for children or youth of the appropriate age. This education should consider programs such as the National Runaway Safeline and others studied by

the task force. Any curriculums for children and youth should be made public and provided to parents and caregivers of children and youth residing in out-of-home care.

The training curriculums for children and youth should be cognizant of the race, ethnicity, language, gender expression, disability status, sexual orientation, national origin, and income of the children and youth in care.<sup>36</sup> Statute should require the regular review and revision of such training and provide opportunities for public feedback.

### DIRECTIVE SEVEN

## Analyze how entities responsible for the care of youth who run away from care can coordinate a thorough and consistent response.

Despite the wide and longstanding acknowledgment that children and youth who run away from care require unique considerations from entities attempting to locate them, Colorado currently has no standard response to these cases. This includes circumstances in which children and youth with established histories of dangerous behaviors run away from care. Additionally, there is no single point of contact to receive reports of a child or youth who has run away from care. As a result, the recovery and care of a child or youth is largely dependent on the jurisdiction where they are located and the entity that finds them first.

Colorado law only requires immediate or 24-hour reporting of children or youth who have run away from care. However, other states have dedicated response units – sometimes referred to as absconder units – that prioritize locating children and youth who have run away from care. These units prioritize locating children and youth based on specific criteria, much like the criteria and response protocols recommended above. The task force considered these units as a method of bringing more urgency and continuity when responding to reports of children and youth who have run away from care. While there are several considerations regarding the scope, authority and placement of such a unit in Colorado, members were generally in agreement that the implementation of such a unit is a key component of the task force's recommendations to create standard and effective procedures and care for children and youth.

Task force members considered examples from Tennessee, Texas and Washington D.C.<sup>37</sup> Based on this research the majority of members recognized the benefits of establishing a standard, statewide response unit. The development of a centralized response unit would eliminate the tedious process of implementing a uniform protocol and training to the state's more than 200 law enforcement agencies. Still, there were several components of a dedicated response unit the task force wrestled with, beginning with the potential for continued traumatization of children and youth by implementing a unit that resembles law enforcement.

The task force also discussed the unit's authority and scope. Of particular concern was the unit's ability to utilize physical means to return children and youth to care after they are located. Generally, some members felt that providing the unit with the authority to physically force children and youth back to care was necessary. Others feared this ability could lead to potential criminal charges against children and youth who resist and would erode the needed trust between children and youth and those providing care. Again, all members noted concerns about disparate treatment of children and youth of color. They noted that children and youth of color are more likely to experience an increase in the use of physical force.

<sup>36</sup> Such demographic information should be congruent with the collection of demographic information required under Senate Bill 24-200.

<sup>37</sup> See [State Intervention Policies when Children Run from Care](#).



Task force members were unanimous that any dedicated response unit must be grounded in a trauma-informed approach. The recovery of children and youth must not be centered solely in the investigative process, but also in the well-being and care of children and youth who are missing. Members discussed the need to balance an approach that lessened possible negative impacts, but also evoked the recognition of keeping children, youth and the community safe. Members also emphasized that any centralized unit must be adequately trained in the impacts of implicit bias on children and youth of color, as well as aware of the disparate impact the unit may have on children and youth of color, those with disabilities and those with acute behavioral, mental and intellectual needs.

The development of a centralized response unit comprised of members from multiple disciplines was also discussed. For example, instead of dedicated staff for the unit, the unit would consist of professionals “on call” to respond. Such professionals may be members of law enforcement, caseworkers and mental health professionals. The task force acknowledged that – regardless of the composition of the unit – the unit must apply the standard risk criteria and response protocols proposed in Recommendations 3(A) and 3(B). This would ensure continuity across the state in how professionals respond to children and youth who have run away, as well as consistency in how information is gathered from children and youth after they return to care. Regardless of structure, the majority of members felt that placement of the unit within CDHS would be ideal, given CDHS’s current responsibility to license and monitor out-of-home placement facilities. This placement would also allow for access to the Trails system and the unique resources provided by each county department of human services.

Finally, members recognized that the success of any centralized unit would be contingent on prompt and full data sharing. Confidentiality of such information, and consideration of who accesses it, was discussed in detail. However, the unit must have access to the information necessary for it to adequately locate and serve children and youth who run away from care.

## Recommendation for Directive Seven

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**“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 run away behaviors.”**  
(C.R.S. §19-3.3-11(5)(g))

The Timothy Montoya Task Force to Prevent Youth from Running Away from Out-of-Home Placement has one recommendation to develop a consistent, prompt and effective response to locate children and youth after they have run away from care. Having considered various policy options to ensure that responses to children or youth running away are handled in a timely manner and with necessary attention to locate a child or youth before harm, the task force recommends the following:

### Recommendation 7(A): Develop a Statewide Response Unit

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The Colorado General Assembly should propose and fund legislation to secure a third-party consultant or obtain services from an institution of higher education to develop a statewide response unit dedicated to locating children and youth after they have run away from care. The selected third-party consultant or institution of higher education should develop a public-facing plan detailing key components of the unit. The legislation should implement the plan and unit, and require its use by providers, county departments of human services and the Colorado Department of Human Services.

The legislation should place the unit within the Colorado Department of Human Services and be appropriately funded and staffed. The legislation should require the Colorado Department of Human Services to include members of this task force in the development of applicable regulations for the administration of this unit.

The selected third-party consultant or institution of higher education should incorporate the following into its plan:

- » Use of the standard risk criteria of a runaway incident detailed in Recommendation 3(A).
- » Use of the multi-tiered categories of risk detailed

in Recommendation 3(A). Use of the individual response plans created by children and youth based on the pre-admission and post-run recovery screening tools detailed in Recommendation 6(C).

- » Use of the standard response protocols detailed in Recommendation 3(B).

Additionally, the selected third-party consultant or institution of higher education should incorporate the following components:

- » The development and implementation of protocols for the unit that incorporate prevention efforts to reduce the likelihood of subsequent attempts to run away.
  - » A clear delineation of the unit's scope and authority. This analysis should include an assessment of whether the unit should be permitted to detain, restrain or physically force a child or youth to care.
  - » The considerations of how this unit may adopt similar tactics currently utilized in crisis response units.
  - » Standards that require all employees or members of the unit be trained in trauma-informed practices and receive standardized mandatory training.
  - » Ensure that the unit works collaboratively with all out-of-home placement providers through standard response protocols.
- » The development and implementation of protocols and mechanisms to ensure the unit will have access to and share pertinent data that is necessary for the success of the unit, may aid in the recovery of a child or youth and prevent further runs. The selected third-party consultant or institution of higher education should ensure that proper security and storage of all information and data is utilized by the unit.
  - » The development of a system in Trails to ensure that records related to the unit are consistently accessible throughout the state.
  - » The incorporation of multidisciplinary teams into unit responses and practices.
  - » The development of an information system for the unit staff or members which is conducive to information sharing across multidisciplinary teams. This system may be a distinct component of the framework detailed in Recommendation 1(A), but it must be included in the overall framework.
  - » The consideration of a regionalized model for the unit to adequately address the unique needs and circumstances of urban and rural areas.
  - » The development of procedures to follow if it is discovered that a recovered child or youth has been victimized in some way. This should include a practice that provides the child or youth with a clear understanding of next steps, their rights and how their preferences will be incorporated.

## DIRECTIVE EIGHT

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.

During the two years that the task force was in place, members repeatedly acknowledged the current limitations created by lack of funding, and the need for adequate funding for the success of any recommended programs or systems. Still, members worked to envision a continuum of care that would best serve these children and youth. They did so with the belief that the urgency in building such a system would be recognized by those with the potential to fund it.

Throughout this report, and for each directive above, the task force requests that each recommendation be fully funded. Without the needed funds, Colorado will continue to fail children and youth who run away from care and the issues that precipitated this task force will continue.

## Response to Directive Eight

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“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.” (C.R.S. §19-3.3-111(5)(h))

The Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement recommends the Colorado General Assembly support the recommendations detailed above through legislation and appropriate funding. Supporting these recommendations will dramatically improve communication between the agencies responsible for helping these children and youth and will create a coordinated system of care for children and youth who run from out-of-home placements.

## Conclusion

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Pursuant to C.R.S. 19-3.3-111(7)(b), the CPO proudly presents the Timothy Montoya Task Force to Prevent Youth from Running from Out-of-Home Placement’s final report to the Colorado General Assembly, Office of the Governor and people of Colorado.

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