CHILD FATALITY PREVENTION SYSTEM: 2022 ANNUAL LEGISLATIVE REPORT

DOCUMENT INFORMATION

TITLE: COLORADO CHILD FATALITY PREVENTION SYSTEM, 2022 ANNUAL LEGISLATIVE REPORT SUBMITTED BY: THE MEMBERS OF THE COLORADO CHILD FATALITY PREVENTION SYSTEM STATE REVIEW TEAM

SUBJECT: THIS REPORT IDENTIFIES RECOMMENDATIONS TO PREVENT CHILD DEATHS IN COLORADO AND PROVIDES AN OVERVIEW OF PROGRAMMATIC ACCOMPLISHMENTS FOR STATE FISCAL YEAR 2021-22, AS REQUIRED IN STATUTE.

STATUTE: CHILD FATALITY PREVENTION ACT; ARTICLE 20.5 SECTIONS 401-409 OF TITLE 25 OF THE COLORADO REVISED STATUTES

DATE: JULY 1, 2022

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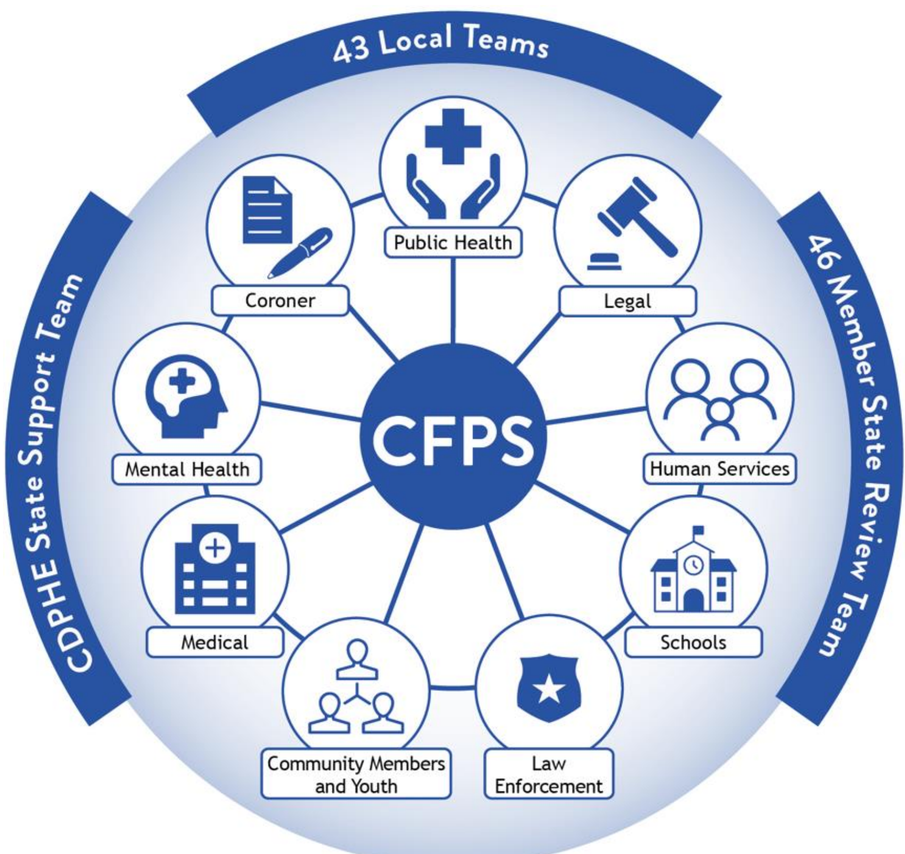
ACKNOWLEDGMENTS

It is with deepest sympathy and respect that we dedicate this report to the memory of those children and families represented within these pages.

Dedicated advocates across the state make this report possible. Thank you to all members and partners of the Child Fatality Prevention System who give their time and efforts to reviewing cases and entering data, developing and implementing prevention recommendations, and preventing child deaths in Colorado. For more information on the Child Fatality Prevention System, visit www.cochildfatalityprevention.com. This report can be found online at www.cochildfatalityprevention.com/p/reports.html.

INTRODUCTION

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide network that focuses on preventing child deaths. CFPS applies a public health approach to prevent child deaths by aggregating data from individual child deaths, describing trends and patterns of the deaths, and recommending prevention strategies. CFPS has been conducting retrospective reviews of child deaths since 1989. Housed at the Colorado Department of Public Health and Environment (CDPHE), CFPS consists of local child fatality prevention review teams (local teams), a 46-member State Review Team, and the CDPHE state support team. This figure below shows the CFPS structure and the variety of partners who participate in the system.



CFPS teams review infant, child, and youth deaths that occur in Colorado due to undetermined causes, injury, violence, motor vehicle and other transportation, child maltreatment, sudden unexpected infant death, and suicide. Data from these case reviews show trends and patterns in these deaths and help CFPS identify strategies to prevent future deaths. The CFPS State Review Team develops recommendations for how to prevent child deaths in an annual report. As mandated in statute, this report identifies recommendations to promote the safety and well-being of children in Colorado and provides an overview of programmatic accomplishments for state Fiscal Year (FY) 2021-22. This report also includes data from deaths that occurred from 2016-2020.

CFPS DATA OVERVIEW

For purposes of this brief, ***inequities*** are defined as systemic, avoidable, and unjust factors that prevent people from reaching their highest level of health. ***Disparities*** are differences in health outcomes between people related to social or demographic factors such as race, ethnicity, gender, sexual orientation, or geographic region. Measuring disparities helps measure our progress toward achieving equity.[1,2]

The impact of policies and systems on child deaths

Generations of social, economic, and environmental inequities contribute to the deaths of infants, children, and youth.[3] People exposed to these factors (outlined in the table below) experience additional harm, resulting in higher rates of death. When interpreting the data, it is critical to not lose sight of these systemic, avoidable, and unjust factors. Researchers work towards understanding how geography, race, ethnicity, sexual orientation, and gender identity correlate with health. It is critical that data systems like CFPS identify and understand the life-long inequities that persist across groups in order to eliminate them. When limitations in the data system exist due to how data are collected, or because data are not collected, CFPS strives to provide additional context and research about how inequities impact child deaths. By changing policies and systems that create and perpetuate inequities, CFPS can reduce the number of child deaths that occur in Colorado. Examples of these inequities include, but are not limited to:

RURAL AND FRONTIER GEOGRAPHY	RACE AND ETHNICITY	SEXUAL ORIENTATION AND GENDER IDENTITY
Limited access to Level 1 trauma centers and mental and behavioral health services.[4] Increased stigma associated with mental illness and seeking help.[5] Longer response times by emergency medical services.[6] **→ These and other factors contribute to higher death**	Racism, discrimination, and historical trauma.[9,10] Limited access to high-quality education,[11] employment opportunities,[12] healthy foods,[13] culturally traditional foods,[14] and health care.[15] Chronic stress.[16] **→ These factors result in lasting health impacts for**	Discrimination, stigma, and bias.[20] Rejection from family, friends, and community.[21] Non-inclusive school curricula and inadequate anti-harassment policies.[22] Insufficient access to LGBTQ+-informed health care.[23] **→ This chronic social stress that LGBTQ+**

rates in rural areas, including suicide[7] and passenger vehicle deaths.[8]	people of color that include infant mortality,[17] high rates of homicide and gun violence,[18] and increased motor vehicle deaths.[19]	children and youth experience influences health across the lifespan, including higher rates of suicide[24] and substance use.[25]

CFPS Data from 2016-2020

5 deaths every week

From 2016 to 2020, 40.0% of deaths occurring in Colorado among infants, children, and youth under age 18 were due to injury and violence. **That is nearly an average of 5 deaths every week.**

251

CFPS reviewed 251 deaths from 2020. That is 19 more deaths than in 2019.

33.2%

There is a **connection between early experiences of child maltreatment and future deaths.** Nearly 33.2% of children and youth who died by suicide previously experienced child maltreatment as a victim.

19.6%

CFPS teams determined that **the COVID-19 pandemic indirectly contributed to 19.6% of deaths reviewed** by CFPS that occurred between March 1, 2020 and December 31, 2020.

2.1 per 100,000

The rate of **poisoning and overdose deaths increased significantly across the review period**, from 0.6 per 100,000 population in 2016 to 2.1 per 100,000 population in 2020.

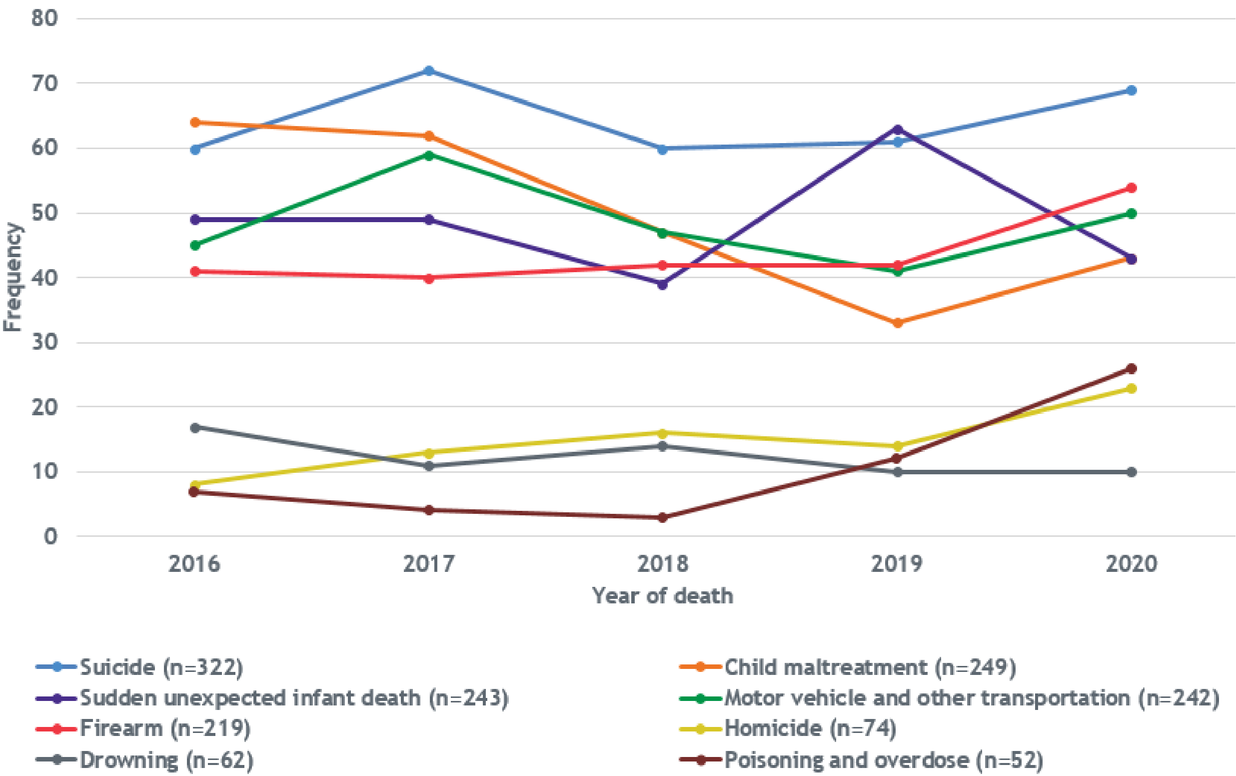
76.9%

In 2019, 33.3% of unintentional overdose deaths reviewed by CFPS involved fentanyl. This increased to 76.9% in 2020.

Data in this report come from reviews of deaths among those younger than 18 years of age occurring in Colorado between 2016 and 2020. CFPS uses death certificates to identify deaths among this population. The leading causes of death for CFPS among those younger than age 18 are suicide, child maltreatment, sudden unexpected infant death (SUID), motor vehicle and other transportation incidents, and firearms. Figure 2 shows the leading causes of death among people under age 18 between 2016 and 2020. All leading causes of death, with the exception of SUID and drowning, increased between 2019 and 2020. CFPS will monitor these trends in the coming years. More details about trends over time are available in a queryable CFPS data dashboard and cause-specific data briefs located at www.cochildfatalityprevention.com/p/reports.html.

The overall rate of deaths reviewed by CFPS for the period was 17.9 per 100,000 Colorado residents. This rate combines all causes of death reviewed by CFPS and is interpreted as the overall rate of death among Colorado residents younger than age 18 due to injury and violence. The overall rate ranged from 16.7 per 100,000 population in 2016 to 19.3 per 100,000 population in 2020. While the upward trend in the rate across the period was not statistically significant, CFPS monitors this trend closely.

Figure 2. Leading causes of death occurring among those younger than age 18 in Colorado and reviewed by CFPS by year, 2016-2020 (n=1202)



Across several of the leading causes of death, CFPS observed significant disparities for non-Hispanic Black, non-Hispanic American Indian or Alaska Native, and Hispanic infants, children, and youth, as well as for young people residing in rural counties in Colorado. Disparities result from historical trauma and the social conditions facilitated by racism and discrimination and from limited resources and extreme social and geographic isolation. Changing policies and systems that create and perpetuate inequities can reduce the number of child deaths that occur in Colorado. More information about the impact of social factors on child deaths is outlined in the CFPS Data Overview section of this report, in cause-specific 2016-2020 data briefs, and in the report: *The Role of Policies and Systems in Child Deaths in Colorado*. All are available here www.cochildfatalityprevention.com/p/reports.html.

Non-Hispanic Black infants, children, and youth were…	Infants, children, and youth residing in frontier counties in Colorado were…
20.6x as likely to die by homicide* **5.8x** as likely to die by poisoning/overdose* **3.5x** as likely to die by child maltreatment* **3.2x** as likely to die by SUID* **3.1x** as likely to die by firearm* **2.7x** as likely to die by drowning	**4.9x** as likely to die in motor vehicle crashes* **1.5x** as likely to die by firearm **1.5x** as likely to die by SUID
…when compared with non-Hispanic white infants, children, and youth.	...when compared with those living in an urban county.

**Difference is statistically significant.*

The impact of the COVID-19 pandemic on child deaths.
The COVID-19 pandemic has had a resounding impact on the lives of children and their families and communities, in ways that many are still working to fully comprehend. In addition to deaths caused directly by COVID-19 where it was the cause of death, child deaths may be indirectly related to COVID-19. In an effort to understand how COVID-19 indirectly impacts child deaths, the National Center for Fatality Review and Prevention provides guidance to use when reviewing deaths occurring after March 1, 2020 . This guidance asks teams to consider whether the death was indirectly related to COVID-19 as a result of:

- Service Delivery Issues (Was death related to the loss or disruption of usual services or health care?)
- Psychological Issues (Was death related to the physical and psychological stress created by the pandemic?)
- Economic Issues (Was death related to financial strain during the pandemic, including job loss, lost wages, limited income, food or housing insecurity?)
- Environmental Issues (Was death related to worsening environmental factors like poor air quality, poor water quality, or overcrowding during the pandemic?)

Ultimately, CFPS teams determined that COVID-19 indirectly contributed to 19.6% (n=41) of deaths reviewed by CFPS that occurred between March 1, 2020 and December 31, 2020. When separated by cause of death, teams determined that COVID indirectly contributed to 60.7% (n=34) of suicide deaths, 38.3% (n=18) of firearm deaths, and 15.8% (n=3) of homicide deaths during this time period. As outlined above, COVID-19 may have impacted these deaths through lack of access to care, economic and psychological stressors, and other factors. As the pandemic continues and CFPS and others continue to try to assess indirect impacts of COVID-19 on child deaths in the state, teams will continue to answer these questions for child deaths occurring in 2021 and beyond.

CFPS RECOMMENDATIONS TO PREVENT CHILD DEATHS

Colorado policymakers and communities can play a critical role in ensuring the health and well-being of infants, children, and youth and their families by supporting policies that help families thrive. CFPS members recommend the following evidence-based strategies to prevent child death in Colorado. These recommendations are based on the collective expertise of CFPS and do not reflect the official position of CDPHE or of any individual CFPS member organization. For more information on the process used to develop and prioritize these recommendations, please read the CFPS Community Engagement section below.

Recommendation	Description
Overdose Prevention	Support policies that increase funding to prevent overdose, including education campaigns and harm reduction efforts.
Caregiver Behavioral Health	Support policies to improve caregiver behavioral health by: 1. Increasing supports for behavioral health treatment; 2. Increasing access to respite care; and 3. Educating caregivers on social-emotional wellness and ways that caregivers can support young people's behavioral health.
Interagency Information Sharing	Support policies that address barriers to interagency information sharing among providers who support young people.
Community Crisis Response	Support policies that increase funding to support non-police community-based crisis response.
Telehealth Services	Support policies that increase access to telehealth services for behavioral health.
Out-of-School Programs to Build Youth Connections	Support policies that increase youth access to community-based programs and supports outside of school.

CFPS Community Engagement

Each year, CFPS partners participate in a community engagement process to develop and prioritize prevention recommendations based on information gathered from deaths that occur among children in Colorado. For the 2022 report, this process included: 1) reviewing the 2016-2020 CFPS data and local team prevention recommendations; 2) discussing prevention recommendations, including review of the best available evidence for each recommendation; 3) partnering with community advisory councils: Youth Partnership for Health and the Community Action Board; and 4) prioritizing prevention recommendations.

2016-2020 DATA PRESENTATION AND LOCAL TEAM PREVENTION RECOMMENDATIONS

To review the 2016-2020 data, partners participated in a two-hour online data presentation, including a state overview and data on leading causes of death for infants, children, and youth under age 18 in Colorado: child and youth suicide, child maltreatment, motor vehicle and other transportation, SUID, firearm, unintentional drowning, homicide, and unintentional poisoning. A recording is available at www.cochildfatalityprevention.com/p/reports.html.

For each child death case reviewed, teams develop recommendations to prevent future similar deaths. For the 251 child deaths that occurred in 2020 and were reviewed by teams in 2021, local teams made over 500 prevention recommendations. These recommendations ranged from providing additional services and supports to families, to changing organizational policies and state laws, to improve the health of infants, children, youth, and their families. On an annual basis, the CFPS state support team aggregates these recommendations and shares them widely with system partners. Local team recommendations form the basis for the prevention recommendations in the legislative report.

PARTNERSHIP WITH COMMUNITY ADVISORY COUNCILS

In an effort to include more community voice in the development of 2022 prevention recommendations and to continue ongoing partnerships with community members, CFPS again consulted the following two community advisory boards.

The **Youth Partnership for Health (YPH)** consists of youth consultants, ages 13-19, representing youth from across Colorado, all selected for their unique experiences that serve as a foundation from which they can provide open and honest feedback. YPH serves as a catalyst for improving outcomes for all young people statewide and includes members who are passionate about the health and well-being of youth. CDPHE compensates YPH members as consultants to provide feedback and suggestions to state and community partners who are working to positively impact the lives of young people in Colorado.

Over the past several years, CFPS has been fortunate to partner with YPH to share data and discuss prevention recommendations. For the 2022 Legislative Report, YPH continued to call out the need for behavioral health supports for young people in Colorado. Specifically, YPH spoke to the need to reduce stigma, ensure culturally responsive care, and help youth build connections, both inside and out of school, as well as ensure leadership opportunities for

young people. YPH also spoke to the need for better connections between CFPS and schools, school districts, and the ongoing need for families and community members to be engaged in CFPS work, especially through social media.

The **Community Action Board (CAB)** is composed of 13 members with a variety of identities and lived experiences. CAB members represent the communities most impacted by, and often left out of, conversations and decisions about public health. CDPHE designed and organized the CAB after hearing feedback from both local and state agencies regarding ways to engage with the communities they serve. The CAB began meeting in fall 2019 to influence long-lasting policy, systems, and environmental changes to CDPHE programs and procedures.

In state FY 2021-22, the CAB again provided feedback on CFPS program and prevention recommendations. The CFPS state support team presented 2016-2020 state level data and the 2021 prevention recommendations and spoke with CAB members about how their past feedback was used and what might be missing or needed to strengthen future reports. CAB members shared several recommendations to improve the work of CFPS:

- Share CFPS data and recommendations with people driving change in the state beyond the policymakers.
- Engage communities and share their stories but not in a way that exploits people's pain and loss and only focuses on problems.
- Diversify the public health workforce.
- Create systems that follow families and wraparound to support them.
- Invest in a crisis response system that is non-punitive care for behavioral health crises, such as mobile response units and mobile health care, etc.

CFPS incorporated feedback from the CAB and YPH into this report. CFPS is committed to increasing community engagement in the process to develop, implement, and evaluate prevention recommendations. CFPS will continue to partner with both advisory councils and seek engagement and feedback to ensure that those most impacted by this work have a voice.

PREVENTION RECOMMENDATIONS DISCUSSIONS AND PRIORITIZATION

After reviewing the 2016-2020 data, local team prevention recommendations, and YPH and CAB feedback, system partners discussed which prevention recommendations to include in the 2022 Legislative Report. During these conversations, partners on the CFPS State Review Team and across the local teams then voted on which recommendations to include in the report, considering the discussions and prioritization criteria: evidence base, connection to the CFPS data, impact on equity and unintended consequences, the population health impact(s), and if the recommendation originated from the local teams.

OVERDOSE PREVENTION

SUPPORT POLICIES THAT INCREASE FUNDING TO PREVENT OVERDOSE, INCLUDING EDUCATION CAMPAIGNS AND HARM REDUCTION EFFORTS.

Overdose deaths among those under age 18 in Colorado increased significantly between 2016 and 2020. The rate in 2016 was 0.6 per 100,000 in 2016 and jumped to 2.1 per 100,000 in 2020. The overall rate of overdose deaths for the period was 0.8 per 100,000 population in Colorado, significantly higher than the national rate over the same period (0.4 per 100,000 population). The majority of those who died were aged 15 to 17 (75.0%, n=39).

Also concerning are the racial and ethnic disparities in overdose deaths and the large increase in overdose deaths that include fentanyl:

- From 2016-2020, non-Hispanic Black children and youth were 5.8 times more likely to die by overdose than their white peers. Similarly, Hispanic children and youth were 2.9 times more likely to die by overdose than their white peers. The causes for racial and ethnic disparities in health are complex. Disparities likely result from historically rooted patterns of racism and discrimination, including persistent structural racism.
- Prior to 2019, none of the overdose deaths that occurred in Colorado among those under age 18 involved fentanyl. In 2019, 33.3% (n=4) of overdose deaths involved fentanyl, and this increased to 76.9% (n=20) in 2020. This is consistent with national data showing rises in fentanyl-involved deaths. CFPS will monitor this trend closely.

> Overdose and poisoning deaths include those of accidental and undetermined manners of death, as determined by the coroner. These can include deaths due to overdose by prescription, illicit, or over-the-counter drugs or may also result from poisoning with other substances, such as household cleaners, carbon monoxide, plants, or pesticides.
> It does not include intentional deaths (i.e., deaths that are the result of homicide or suicide), although making those determinations in some deaths can be difficult.

Due to the increasing number of overdose deaths in Colorado among people under age 18 and the particular concern about the increase in overdose deaths involving fentanyl, more resources are needed to support evidence-based educational campaigns to inform Coloradans about fentanyl and to expand availability of harm reduction resources, including medication for addiction treatment (MAT) and distribution of naloxone, fentanyl test strips, and safe storage options.

Education about fentanyl. A synthetic opioid that is up to 50 times more potent than heroin and 100 times more potent than morphine, fentanyl causes overdose symptoms more quickly than heroin or other opioids, underlining the importance of education on how to respond in a timely manner. Fentanyl is now widespread in the drug supply in Colorado and comes in pills, pure powders, and powder mixed with other illicit drugs such as methamphetamine, cocaine, heroin, and benzodiazepines. It cannot be seen, tasted or smelled when mixed into other

drugs. Because it is highly potent and widespread, the general public in Colorado would benefit from more education to help prevent overdoses.

Education for first responders. Law enforcement officers, emergency medical services professionals, and medical professionals are increasingly responding to overdoses as part of their roles. It's imperative that these professionals know how to respond swiftly to overdoses. First responders may be concerned that they may be at risk of overdosing themselves by coming into contact with opioids or someone who is overdosing; however, airborne and dermal exposure to fentanyl/opioids does not represent a significant or realistic threat to a person's safety. Perpetuation of this myth can prevent first responders and others from rendering aid quickly due to fear of exposure.

Evidence-based education to young people. Young people need access to evidence-based education that focuses on building social-emotional support, autonomy, and knowledge of how to stay safer if they do say "yes" to drugs. Research shows that education that focuses on abstinence only or fear-based messaging is not effective in deterring youth substance use and leaves young people without tools to reduce their risk should they or their peers initiate substance use.

Harm reduction. More funding for harm reduction is needed in Colorado to prevent overdose and reduce the risks associated with drug use. This includes increasing access to medication for addiction treatment, increasing distribution of the life-saving overdose reversal drug naloxone, test strips for people to check if substances include fentanyl, and ways to safely store substances and medications, such as lockboxes and lock bags.

Safe Storage of Firearms, Substances, and Medications

One way that caregivers and parents can help make sure that young people are safe in their homes is to lock up medications (both prescription and over-the-counter), substances (such as bleach, illicit and legal drugs, and other toxic materials), and firearms. Simply restricting access to these hazards by locking them up may help prevent deaths among young people in Colorado, including overdose deaths, deaths caused by poisoning, suicides, homicides, and unintentional firearm deaths.

During the 2022 legislative session, Colorado legislators increased funding for overdose prevention efforts and harm reduction strategies. HB22-1326 (Fentanyl Accountability and Prevention Act) allocated $5 million for a statewide prevention and education campaign to address fentanyl outreach and awareness needs in Colorado. Educational efforts will include development of a statewide fentanyl prevention and education campaign. The bill also included over $26 million for harm reduction resources, including naloxone and fentanyl test strips, expanded the types of entities eligible to receive naloxone at no cost from the state's Naloxone Bulk Purchase Fund, and expanded the types of eligible entities and permissible uses of the Harm Reduction Grant Program. The efforts outlined in the bill will be evaluated by an independent body for effectiveness.

CAREGIVER BEHAVIORAL HEALTH

SUPPORT POLICIES TO IMPROVE CAREGIVER BEHAVIORAL HEALTH BY:

1. **Increasing supports for behavioral health treatment;**
2. **Increasing access to respite care; and**
3. **Educating caregivers on social-emotional wellness and ways that caregivers can support young people's behavioral health.**

Caregivers, including parents and other adults who support and care for infants, children, and youth, have some of the biggest impacts on young people’s lives. Whether feeding and changing an infant, making sure a child wears a helmet while they skateboard, or cheering on a young person after a school performance, these adults do a lot to support the health and well-being of the young people in their lives. It’s imperative that these caregivers themselves have the support that they need to be the best caregivers they can be.

Poor caregiver behavioral health can impact the health and well-being of the young people they take care of and can even contribute to child deaths. Research shows that high levels of caregiver stress and poor behavioral health contributes to child maltreatment, for example.[26] Experiences of child maltreatment are a risk factor for child deaths caused by child maltreatment and are connected to other health outcomes later in life like youth suicide.

While the factors that contribute to caregiver behavioral health are complex, the stress of caregiving may contribute to poor behavioral health. Free or low-cost respite care may offer a solution. Broadly defined as a temporary break in caregiving, respite care allows caregivers to step back from their responsibilities and take time for themselves. Programs like Colorado Respite Coalition, part of Easterseals Colorado, provide training and raise awareness about the importance of respite care as well as providing funding for organizations offering respite care and vouchers for caregivers who need respite care. Despite efforts to increase access to respite care across the state, the need far outweighs the supports and care available.[27]

When caregivers have behavioral health needs, they should have access to supports and treatment, including both crisis care and ongoing care. Caregivers need behavioral health treatment that accommodates their needs as caregivers and addresses barriers to care. One example of a program that supports caregivers’ behavioral health and recovery is Illuminating Child Care, an exempt operated child care program. Developed by Illuminate Colorado, qualified early childhood teachers provide no-cost, on-site child care to enrolled children ages six weeks to five years while their caregivers are accessing substance use disorder treatment and recovery support on site through established partnerships with behavioral health facilities. This program provides child care so that caregivers can get the treatment that they need without worry about who is caring for their child.

Caregivers who are Black, Indigenous, and People of Color and/or LGBTQ+ may experience even more stress and lack of access to behavioral health supports as a result of experiencing racism and discrimination. Behavioral health should be offered in non-traditional settings to meet these needs, such as through telehealth. Behavioral health care should also be provided by professionals that meet the diverse cultural and linguistic needs of caregivers and understand community-specific concerns about seeking care for behavioral health. Behavioral health care providers should also be affirming of caregivers’ sexual orientations and gender identities, such as using the correct gender pronouns and not making assumptions about someone’s identity or sexuality.

Because the health of young people is tied to the health of their caregivers, it’s essential that caregivers understand the connection and receive education on social-emotional wellness and other ways to support their own and young people’s behavioral health. Ultimately, healthier adults, parents, and caregivers raise healthier children and youth, which has the potential to prevent many types of child deaths.

INTERAGENCY INFORMATION SHARING

SUPPORT POLICIES THAT ADDRESS BARRIERS TO INTERAGENCY INFORMATION SHARING AMONG PROVIDERS WHO SUPPORT YOUNG PEOPLE AND THEIR FAMILIES ACROSS SYSTEMS.

Although children and families often interact with multiple systems and public agencies, such as human services, law enforcement, medical and behavioral health providers, and schools, these agencies do not always have the ability to share information about a child or their family with each other. Legal restrictions and confidentiality concerns may prohibit or limit the amount or type of information shared between agencies. Comprehensive access to information across agencies may prevent child deaths from occurring by better serving and supporting children and their families.

Improving information sharing will strengthen efforts to support families by helping those who work with families and families themselves to access the support and resources they need and make decisions about child safety and well-being accordingly. For example, if a child's health care provider is aware that a young person is having problems with school or that their family is receiving services from child welfare, they may be better able to support the young person and their family. Another example is that better information sharing can also help to improve the child death review process. Among 2016-2020 deaths reviewed by CFPS, confidentiality issues among team members prevented the full exchange of information during 7.2% (n=87) of reviews. Improving information sharing could support the future exchange of this information to promote more effective reviews.

Efforts to share information across systems to better meet individuals' and families' social needs are already underway in Colorado. Since 2017, partners from various sectors across Colorado have come together to support the building of social health information exchanges (S-HIE). S-HIE supports coordinated and connected care across systems including health care, government agencies, and community-based organizations. In these systems, agencies and individuals themselves can access both aggregated and individual-level data and information. According to experts in the S-HIE field, the benefits of creating systems that share information include improved care that better meets the unique needs of individuals and families; better coordination among agencies and services providers across communities; enhanced relationships among agencies, providers, and families; and aggregated data for community planning to better understand gaps in resources, which resources are being used or not, etc.[28]

Improved communication and information sharing between agencies will enhance systematic responses to families' needs and support care that is based on the whole person. Despite the need for this type of information sharing, appropriate concerns about confidentiality exist. Agencies and partners can convene to set in place data sharing agreements, in order to minimize confidentiality concerns and risks. Enhancing the ability of providers and agencies in Colorado to share information is a key component of preventing child deaths and supporting children and families to thrive.

COMMUNITY CRISIS RESPONSE

SUPPORT POLICIES THAT INCREASE FUNDING TO SUPPORT NON-POLICE COMMUNITY-BASED CRISIS RESPONSE.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the Child Fatality Prevention System (CFPS) State Review Team collaborates with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT) to make joint recommendations to prevent child fatalities. Based on the systematic review of cases reviewed by both systems, CFRT and CFPS jointly recommend supporting policies that increase funding to support non-police community-based crisis response. The process to identify this recommendation began with CFRT and CFPS staff meeting to review prevention recommendations across the two programs for child deaths reviewed in 2020 by both CFRT and CFPS. Also for the first time ever, CFRT and CFPS team members met in February 2022 to learn about each team's work and how the two programs partner as part of a comprehensive child death review and prevention process, hear updates on past joint recommendations, and discuss possible joint recommendations. CFRT and CFPS members discussed options and identified the need for comprehensive behavioral health crisis response as a common theme and possible recommendation.

This is a joint Colorado Department of Human Services (CDHS) Child Fatality Review Team and CFPS State Review Team recommendation. The CDHS CFRT reviews incidents of fatal, near-fatal, or egregious abuse or neglect determined to be a result of child maltreatment when the child or family had previous involvement with the child welfare system within the last three years. CFRT identifies factors that may have led to the incident and assesses the sufficiency and quality of services provided to families and their prior involvement with the child welfare system. CFRT puts forth policy and practice recommendations based on identified strengths and systemic gaps and/or deficiencies that may help prevent future incidents of abuse or neglect. These recommendations also strengthen systems that deliver services to children and families.

Young people in Colorado have many unmet behavioral health needs, especially during acute crisis situations. Crises are typically short-term, acute instances where individuals can help those in crisis in a non-traumatizing way, leading to better long-term outcomes. While Colorado has made strides to increase access to behavioral health care for young people, such as the creation of the I Matter Program, which provides at least three free behavioral health sessions for Colorado youth, and passage of HB22-1052 (Promoting Crisis Services To Students) to make sure that all schools provide information about how to reach Colorado Crisis Services to their students, more efforts are needed to support young people in crisis. One potential solution is to ensure that youth have access to crisis care in their communities. Community crisis response means care that is available quickly, without extensive travel, and provided by people who know or who are from their cultures and communities. Young people who do not

have access to this type of care for their behavioral health may have an increased risk of thoughts of suicide or suicidal ideation, meaning that community crisis care may also decrease suicide among young people in Colorado.

Research shows that community crisis response has shown to reduce unnecessary hospitalizations for individuals in crisis.[29] Involuntary hospitalizations and coercive care experiences are associated with higher rates of future suicide attempts and deaths.[30] The Colorado Suicide Prevention Commission designated a workgroup investigating the use of forced treatment with people experiencing suicidal thoughts in January of 2019. The workgroup reviewed relevant research and data and developed recommendations which included that there are significant equity-related concerns with forced hospitalization, including methods like seclusion and physical restraints being disproportionately utilized on people of color, and LGTBQ + individuals.[31] Therefore, community-based alternatives should be prioritized and promoted such as: community health workers, doulas, and promotoras.

Community-based workers have been shown to lead to improved health outcomes. For example, doula-based care reduces the need for hospitalizations among pregnant and birthing people.[32] Doulas play an integral part of crisis response by focusing on building a meaningful, trusting relationship with individuals and their families. Doulas not only lead to better health outcomes, but support individuals and families with continuous emotional and physical support they provide before, during, and after a crisis as well as connecting people with resources in the community.[33,34] While the majority of current research shows that doulas have an impact on reducing adverse health outcomes specifically for pregnant or birthing people, the same model and approach to crisis intervention could be translated to youth crisis intervention. Currently, states like New Jersey and Oregon mandate coverage of doula services under Medicaid. In Colorado, communities are investing in community-based crisis response programs including: AIM GRASP, a peer-run, community violence response program helping divert youth from gang involvement, and Metro Family Health Navigators, hospital-based family advocates, as two examples.

Another option to create more community-based crisis response are mobile crisis teams (MCTs). MCTs serve as alternatives to emergency department admission and are a widely accepted, effective approach to emergency service delivery.[35,36] Such services are thought to also reduce and even completely eliminate the need for law enforcement intervention, and instead divert those in crisis to a community-based treatment center.[37] Law enforcement response to someone who is in crisis can escalate a situation, which can be attributed to a lack of training and expertise in de-escalation.[38] MCTs can provide psychiatric assessment and crisis stabilization services by meeting the person in crisis where they are. Peer support is also an important aspect of MCTs, as they can often share lived experience, strengthen engagement with the individual in crisis, and build rapport.[39] All modalities of community crisis response should be culturally relevant for those in crisis, including for their families and communities and ensure timely referrals to resources available in the community. Given the benefits of community-based crisis response, policymakers should support this recommendation to improve the lives and outcomes of those experiencing crisis in Colorado.

TELEHEALTH SERVICES

SUPPORT POLICIES THAT INCREASE ACCESS TO TELEHEALTH SERVICES FOR BEHAVIORAL HEALTH.

Over the last two years during the COVID-19 pandemic, young people not only attended school online, but also accessed life-saving behavioral health care online via telehealth. Telehealth provides a way to address common barriers including lack of transportation, inability to leave the house or be in public, as well as privacy concerns due to the stigma associated with seeking and receiving behavioral health care services that may keep many young people from seeking care in-person, especially in rural areas of the state. Of the 322 young people who died by suicide in Colorado from 2016-2020, just over half (53.7%) had received prior mental health services, and even fewer (35.1%) were currently receiving mental health services when they died. This suggests that there is a need for more behavioral health supports for young people, and telehealth care may help provide that access.

Telehealth increases access, quality, and efficiency of health care delivery for all types of health care, including behavioral health. Research suggests that telehealth not only improves access to and quality of care, but also reduces costs.[40,41] The infrastructure for telehealth is well supported. Private and public insurers, including Medicaid, reimburse telehealth services for physical and behavioral health. Additionally, young people are already accessing free behavioral health care through telehealth as part of the I Matter Program, which provides at least three free behavioral health sessions for Colorado youth (cdhs.colorado.gov/behavioral-health/i-matter-program). Colorado should continue to invest in telehealth care options for young people to meet their behavioral health needs.

Despite the benefits and widespread use of telehealth, several important factors impact telehealth and should be considered. Currently, not all communities in Colorado have access to stable and affordable broadband internet to be able to access telehealth services. Internet infrastructure must be supported in the communities that need it most to ensure access to telehealth. Additionally, not all behavioral or health care needs can be met by telehealth because providers might not have the adequate training to support someone experiencing suicidal despair. Therefore, increasing access to telehealth services should coincide with increasing provider competency in supporting those in crisis. The stigma surrounding mental health care can often be exacerbated at home, especially in Black, Indigenous, and people of color (BIPOC) and LGBTQ+ communities, which can be a barrier for people wanting to seek telemental health care, but cannot due to privacy concerns. Additionally, people seeking acute, crisis, in-person care may still face access barriers such as lack of availability of the care they need in their communities or lack of transportation. Due to lack of other care options, people needing crisis care may be more likely to come into contact with law enforcement. Law enforcement intervention in situations where someone is in crisis can often escalate a situation, which can be attributed to a lack of proper training and expertise in de-

escalation. As discussed in the Community Crisis Response recommendation, community-based and mobile crisis teams are a potential solution to support health when telehealth is not an option or when a different crisis case response is needed. Given the potential of telehealth to reduce health care costs and improve access to quality care especially as the COVID-19 pandemic continues, policymakers should continue to support telehealth as an option for behavioral health care in Colorado.

Protective Factors to Prevent Youth Motor Vehicle Deaths

Efforts to prevent motor vehicle related injuries and fatalities among young people include strategies ranging from ensuring young people have the skills and training necessary to learn how to safely drive to graduated driver licensing laws that ensure youth practice driving with minimal distractions. Colorado is also working to improve young driver safety by strengthening interpersonal and systemic protective factors that increase the likelihood of youth engaging in safe driving behaviors and reducing risk factors that increase their likelihood of engaging in unsafe driving behaviors. Identified through CDC research[42] and analysis of Colorado high school student survey data from the Healthy Kids Colorado Survey (HKCS), protective factors such as having relationships with adults they trust and having good behavioral health, are correlated with safer driving behavior among youth.

HKCS results[43] show that risk factors correlated with riskier young driver and passenger behavior among Colorado youth include not feeling safe at school, experiencing housing instability, not having a trusted adult they can go to with a serious problem, not having enough food to eat, and experiencing depression. For example:

- Youth who report not having trusted adults in their lives were over 1.5-2 times as likely to not wear their seat belts, drive after drinking or using cannabis, and ride with an impaired driver.
- Youth who experience depression are over 2 times as likely to drive after drinking alcohol or consuming cannabis, ride with an impaired driver, and report never or rarely wearing their seat belt.

Therefore, strategies to improve behavioral health among young people and their families will likely lead to better driving outcomes among young people. This report includes several strategies to improve behavioral health, such as:

- Increase funding to prevent overdose.
- Improve caregiver behavioral health.
- Increase funding to support non-police community-based crisis response.
- Increase access to telehealth services for behavioral health.
- Increase youth access to community-based programs and supports outside of school.

Implementing these strategies to improve behavioral health among Colorado youth will reduce risky driving behaviors and ultimately may prevent child deaths in motor vehicles.

OUT-OF-SCHOOL PROGRAMS TO BUILD YOUTH CONNECTIONS

SUPPORT POLICIES THAT INCREASE YOUTH ACCESS TO COMMUNITY-BASED PROGRAMS AND SUPPORTS OUTSIDE OF SCHOOL.

Research shows creating connectedness can reduce the onset of suicidal behavior.[43,44] Suicide prevention and behavioral health promotion are community issues, requiring all community organizations and members to come together. Prioritizing out-of-school programs for youth connectedness allow youth at risk for suicide to get connected with peer supports and trusted adults, both of which have been shown to reduce negative behavioral health outcomes, including suicidal ideation.[45] Stronger connections to others increases a person's sense of belonging to a group and helps one gain access to community support.

Black, Indigenous, Youth of Color are more likely to feel suicidal than their white counterparts; these health disparities reflect interconnected systems of discrimination, racism, intergenerational trauma, and trauma related to homophobia, transphobia, and poverty.[46] Additionally, fewer BIPOC youth in Colorado reported having access to a trusted adult to go to for help compared to their white counterparts.[47] The Colorado Suicide Prevention's Youth-Specific Initiatives Workgroup created recommendations which included the need for supporting out-of-school programs in order to create spaces for youth to connect with and seek social support from same-race peers, community leaders, and trusted adults to help address suicide and support behavioral health. Out-of-school programs should also prioritize suicide prevention and behavioral health promotion through a culturally appropriate lens, as most mental health systems center Western, Eurocentric cultural practices and traditions, which often leaves out needs and perspectives of Black, Indigenous, and Youth of Color.[48,49] Given that BIPOC, LGBTQ+ youth populations face heightened discrimination and victimization,[4] youth-serving organizations should also intentionally collaborate, and support BIPOC youth who identify as LGBTQ+. These same-race support systems cultivated in out-of-school youth programs, can help create a safe, and culturally appropriate space for BIPOC youth, and youth identifying as LGBTQ+.

Youth-serving, community-based organizations can be a critical intervention point for at-risk youth for suicide and poor behavioral health. Programs like the Teen Self Care Fair, a community-wide program that helps youth gain access to healthy coping skills and actively partners with Thompson Teens United, and From The Heart Enterprises, an organization that prioritizes mental health awareness for youth like organizing after school enrichment programs help young people who might be in need of support and connection. Additionally, Colorado is fortunate to have state funding allocated to programs that support youth and prevent violence, substance use, and child maltreatment through the Tony Grampsas Youth Services Program (cdhs.colorado.gov/tony-grampsas-youth-services-program). Given the potential for community-based organizations and peer social support networks have for preventing suicide and supporting behavioral health, policymakers should support policies that improve access to these youth-serving organizations.

CFPS RECOMMENDATIONS TO IMPROVE DATA QUALITY

Pursuant to Colorado Revised Statutes (C.R.S.) 25-20.5-407 (1)(g), CFPS is required to report on system strengths and weaknesses identified during the child death review process. For the purpose of the report, “system” is defined as state and local agencies or Colorado laws that potentially impact the health and well-being of children. “Systematic child-related issues” means any issues involving one or more agencies. System strengths are included in **Appendix A: CFPS Prevention Activities: Analysis and Updates on Prevention Recommendations**.

CFPS identified weaknesses primarily related to how data is collected, shared, analyzed, and used by different systems. CFPS prioritized four recommendations to strengthen the quality of child death data. These recommendations call for improving child death investigations, data collection, and data analysis. Enhanced data quality will improve data-informed decisions about which prevention programs and policies to recommend and implement in Colorado.

ENCOURAGE AND INCENTIVIZE LAW ENFORCEMENT AGENCIES AND CORONER OFFICES TO USE THE SUDDEN UNEXPECTED INFANT DEATH INVESTIGATION REPORTING FORM (SUIDIRF) DURING INFANT DEATH SCENE INVESTIGATIONS.

Infant death scene investigations are critical to a comprehensive understanding of how and why an infant dies. A full infant death scene investigation includes a thorough examination of the death scene, a review of clinical history, and an autopsy. CFPS has limited ability to determine the circumstances related to infant deaths when death scene investigators do not conduct a full infant death scene investigation or if they do not complete the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) (www.cdc.gov/sids/SUIDRF.htm). Having this information can help the system identify risk factors associated with infant deaths and improve future prevention efforts.

The CDC designed the SUIDIRF to assist investigative agencies in understanding the circumstances and factors contributing to unexplained infant deaths and to establish a standardized death scene investigation protocol for the investigation of all SUID.[50] The form guides investigators through the steps involved in an investigation, produces information that researchers can use to recognize new threats and risk factors for SUID, and improves the classification of infant deaths that occur in a sleep environment. Information collected on the SUIDIRF includes infant demographics, pregnancy history, infant history, incident scene investigation, incident circumstances, and investigation diagrams.

Although the SUIDIRF is a useful tool for death scene investigators, Colorado historically has among the lowest rates of all states for filling out the SUIDIRF.[51] This may in part be due to death scene investigators’ lack of awareness of the form and training on how to use it. According to the most recent information collected by the National Conference of State Legislatures, only 12 states require special SUID training for infant death scene investigators.[52] Due to promoting the use of the SUIDIRF, Colorado data indicates an increase

in the proportion of SUID investigations where the SUIDIRF was used (53.1% in 2016 to 62.8% in 2020). Since the SUIDIRF encourages the use of doll reenactments as a gold standard practice during the death investigation, Colorado has also seen an increase in the proportion of SUID investigations where doll reenactments were performed (36.7% in 2016 to 44.2% in 2020).

What are doll reenactments? When an infant dies suddenly and unexpectedly, a thorough infant death scene investigation is necessary to accurately determine the cause and manner of death. Doll reenactments are an integral piece of a thorough and complete investigation. With the guidance of death scene investigators, doll reenactments are performed by the person(s) who found the infant unresponsive. Doll reenactments recreate the death scene using a weighted doll to allow investigators to visualize and document the position the infant was placed to sleep, where the infant was found, and other scene details that help investigators understand the circumstances that lead to an infant's death.

Encouraging and incentivizing law enforcement agencies and coroner offices to use the SUIDIRF in Colorado will improve information collected about unexplained infant deaths and enhance SUID prevention efforts across the state. CFPS is committed to ensuring that training is not a barrier to investigators' ability to use the SUIDIRF form. CFPS provides training resources and opportunities to support Colorado's investigators learning about and using this form to support data quality. In FY 2020-21, the CFPS Investigative and Data Quality Subcommittee began the development of a free, web-based training module on infant death investigation, with a particular focus on using the SUIDIRF. In FY 2021-22, the training was finalized and made available to death scene investigators. CFPS will continue widely promoting the training to a variety of professions (e.g., coroner and medical examiner staff, law enforcement, human services, district attorney offices).

ENCOURAGE AND INCENTIVIZE LAW ENFORCEMENT AGENCIES AND CORONER OFFICES TO USE THE COLORADO SUICIDE DEATH INVESTIGATION FORM WHEN INVESTIGATING SUICIDE DEATHS.

Data systems in Colorado, including CFPS and Colorado Violent Death Reporting System (CoVDRS), often have missing and unknown data related to suicide deaths. Death scene investigators typically collect limited information about a child or youth's sexual orientation, gender identity, mental health history, and access to lethal means, especially regarding firearm storage and ownership. From 2016-2020, among the 124 suicide deaths by firearm that occurred among children and youth in Colorado, safe and secure weapon storage data was missing for many of the deaths reviewed. Specifically, information regarding whether the weapon was stored locked was missing for 28.2% (n=35) of the deaths. Information regarding whether the firearm was stored loaded was missing for 50.8% (n=63) of these cases.

To improve the case review process, CFPS recommends that law enforcement agencies and coroner offices implement standardized use of the Suicide Death Investigation Form (cdphe.colorado.gov/suicide-prevention/suicide-investigation-form). This would ensure

investigators consistently collect sexual orientation, gender identity, and detailed circumstance data when investigating a suspected suicide death.

The CFPS Investigative and Data Quality Subcommittee, CDPHE Office of Suicide Prevention (OSP), and CoVDRS drafted the Suicide Death Investigation Form in FY 2016-17. Content experts from numerous organizations worked collaboratively to produce this comprehensive investigation tool, and 10 counties across Colorado piloted the form. The CFPS Investigative and Data Quality Subcommittee gathered feedback from death scene investigators who piloted the form and made improvements based on their suggestions and experience using the form. CDPHE made the form and an accompanying guidance manual available online.

In FY 2020-21, CFPS and OSP developed and implemented a mini-grant program to encourage and incentivize death scene investigators across the state to utilize the form across all age groups. CDPHE awarded mini-grant funding to 10 coroner/medical examiner offices in Colorado with the goals of: 1) increasing utilization of the Suicide Death Investigation Form for all suicide fatalities in the county, 2) bringing staff from coroner agencies and medical examiner offices into local or regional suicide prevention coalitions and working groups, 3) supporting suicide loss survivors, and 4) improving the Suicide Death Investigation Form. CDPHE gathered feedback from the 10 grantees and made improvements to the form based on their suggestions and experience using the form. The new version of the form is available online (cdphe.colorado.gov/suicide-prevention/suicide-investigation-form). CFPS, OSP, and CoVDRS partners continue to promote the form to investigators through presentations at the Colorado Coroners Association and other meetings.

To begin measuring progress on this recommendation, CFPS added two questions to the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System. For each child and youth suicide death, the questions ask: 1) Was a suicide death investigation form (or jurisdictional equivalent) completed during the death scene investigation? and 2) if so, was the form shared with the local child fatality prevention review team to aid in the child death review process? These measures were assessed for child and youth suicide deaths that occurred in 2019 and 2020. Data indicate that Suicide Death Investigation Forms were completed for 26.2% (n=16) of 2019 cases and 34.8% (n=24) of 2020 cases. For cases where a form was completed, the form was shared with the local review team 68.8% (n=11) of the time for 2019, and 100% (n=24) of the time for 2020.

Implementing policies and protocols within agencies investigating potential deaths by suicide will improve the quality of data, increase understanding of the circumstances of suicide deaths in Colorado, and help to identify common risks and points for intervention. For example, OSP relies on data coroners, law enforcement, and other death investigators to collect to guide current and future priorities and funding allocations to prevent suicide in Colorado. These data directly inform opportunities for prevention and intervention and help to identify gaps in programming. The El Paso County Coroner's Office (EPCCO) is leading the way in implementing protocols that improve the understanding of the circumstances of suicide deaths occurring within their jurisdiction. In 2021, the EPCCO added questions about

racism and discrimination to their child death investigation questionnaire. The question specifically asks “Has discrimination or exclusion based on race, gender, sexual orientation, age, disability, or other impacted the decedent or their community?”

The Office of Suicide Prevention at CDPHE has four overarching strategic areas to prevent suicide: improving health system readiness and response to suicide, increasing active analysis and dissemination of suicide-related data, and increasing suicide prevention efforts for priority populations and disparately impacted communities. In support of the department’s strategy to improve data, in FY 2021-22, OSP is continuing an ongoing mini-grant program to encourage and incentivize death scene investigators across the state to utilize the form across all age groups. CFPS is also committed to ensuring that training is not a barrier to investigators' ability to use the Suicide Death Investigation Form. CFPS will continue to provide training resources and opportunities to support Colorado's law enforcement and death scene investigators learning about and using this form to support data quality.

IMPROVE QUALITY OF CFPS CHILD MALTREATMENT DATA BY PROVIDING TECHNICAL ASSISTANCE TO LOCAL TEAMS AND SUPPLEMENTING CFPS DATA WITH OTHER DATA SOURCES.

Child maltreatment is a critical public health issue. Research suggests that child maltreatment is far more prevalent than is currently being reported to human services, possibly affecting up to 25% of people under age 18.[53] The effects of child abuse and neglect are serious and impact people’s well-being and health throughout the rest of their lives. Experiencing child maltreatment can not only lead to bodily harm, but mental and psychological distress, and is associated with later injuries, chronic health concerns, and other forms of violence, including family violence, sexual violence, and suicide.[54] In the most extreme circumstances, child maltreatment may result in death.

Child maltreatment includes physical, sexual, and emotional abuse, as well as neglect. Definitions of what constitutes child maltreatment differ across systems. Colorado Department of Human Services’ work is guided by the statutory and legal definitions of child maltreatment. CFPS on the other hand, defines child maltreatment broadly as an act or failure to act on the part of a parent or caregiver regardless of intent. This broad definition acknowledges that children die from abuse or neglect in Colorado without ever having contact with the child welfare system. CFPS teams make determinations of child maltreatment based on available information from case reviews and professional judgments. The determination is the subjective opinion of the teams.

As a result of these different definitions, case counts do not always align between systems. For example, despite CFPS’s broader definition, teams do not always identify deaths as related to child maltreatment, even when these deaths have been substantiated by county human services. In 2020, teams initially identified 48.1% (n=13) of the 27 child maltreatment deaths substantiated by county departments of human services. The 14 deaths not identified as child maltreatment by local teams during the review were most often found to have

exposure to hazards or poor supervision that contributed to the death but did not rise to the level of child abuse or neglect, according to the opinion of the team. One way CFPS plans to improve child maltreatment data quality is by increasing training to local teams about CFPS' role in identifying when child maltreatment caused or contributed to the deaths. Doing so will move the state toward gaining a more holistic understanding of the number of deaths that are truly related to abuse or neglect.

In addition to local teams determining whether child maltreatment directly caused or contributed to a death, CFPS collects data regarding the history of child maltreatment prior to the death of an infant, child, or youth. Experiences of child maltreatment, considered to be one of the significant Adverse Childhood Experiences,[55] have a large impact on health throughout the lifespan[56] and are associated with future outcomes such as suicide.[57] CFPS is committed to understanding how early experiences of child maltreatment may contribute to the fatal circumstances leading to death among children and youth younger than age 18. Understanding and improving the quality of data regarding the history of child maltreatment will help to identify actions that would reduce future deaths in Colorado.

History of child maltreatment data collected by CFPS includes a referral or substantiation from child protective services or documentation on the autopsy report, law enforcement report, or medical records. However, information about child maltreatment history is missing or unknown for a large proportion of deaths reviewed. To improve CFPS data on child maltreatment history, in FY 2020-21, CFPS developed and executed a Data Use Agreement with the CDHS Administrative Review Division to improve the understanding of the impacts of child maltreatment on child deaths. Prior to the linkage, 2019 CFPS data on history of child maltreatment as a victim was known (e.g., marked either 'Yes' or 'No') for 70.3% of cases. After the linkage, CFPS had this information for 97.8% of cases. In FY 2021-22, CFPS again completed this annual data sharing process leading to more complete data.

STRENGTHEN CFPS DATA QUALITY AND PREVENTION RECOMMENDATIONS BY ENCOURAGING LOCAL TEAMS TO USE AN EQUITY LENS.

Conducting multidisciplinary child death reviews promotes a better understanding of how to prevent future deaths and improve the lives of families and communities. Convening a multidisciplinary review team in Colorado has historically meant bringing together members with a wide variety of professional backgrounds and expertise. This includes coroners, legal professionals, public health, human services, law enforcement, medical staff, and school representatives. Many professionals on the team bring valuable personal and lived experiences to the review. However, the widening disparities in deaths of infants, children, and youth signals the urgent need to conduct training and include more voices in the child death review process. This comprehensive and equitable response to child death review will enable teams to recommend upstream prevention strategies centered on addressing the social determinants of health.

Including community representatives. Child death review teams are more effective when additional team members with lived experiences and who represent the ethnic and cultural diversity in the community are present at the review.[58] Community input at the child death review helps to bring families' lived experiences to the surface and leads to improved understanding of the social and environmental determinants of child deaths. For instance, young people and community representatives may reframe causation of the death to social responsibility, rather than placing blame on individuals (e.g., parents, caregivers). Local teams should compensate youth and community representatives for their time and expertise and, when possible, teams should host meetings at times that are accessible to all members (outside daytime work hours) and provide meals and child care.

CFPS engaged team coordinators about inviting youth and community representatives to meetings at the Shared Risk and Protective Factors Conference in May 2019. In April 2020, CFPS added two questions to the "Review Meeting Process" section of the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System (CRS), the national data collection tool. For each death, the questions ask if a young person, community representative, and/or family leader were present at the review meeting. This will allow the system to measure progress on this recommendation. Data indicate that in 2020, young people participated in 1.2% (n=3) of case reviews and community representatives participated in 12.4% (n=31) of case reviews, indicating significant room for improvement.

Ongoing equity training. Regular training should occur with the entire local team to build knowledge about equity and address internal biases. The whole team should be accountable for shifting toward a social responsibility lens. Training to develop a shared understanding helps the team to create a safe and inclusive space that celebrates and values diversity, including youth and community representatives.

CFPS partners have engaged in a variety of equity-based trainings and resources. To support learning about equity and child deaths, CFPS state support team staff created the CFPS Equity Learning Series, an eight-week virtual learning opportunity that introduces equity and its importance in child death reviews in spring 2020. Beginning in February 2020, system partners participate in two equity-focused trainings each year: one in February and another in September. Training topics have included: an introduction to equity, diversity, and inclusion; implicit bias and microaggressions; reflecting on characteristics of white supremacy culture; and knowing your why. In February 2021, the system went through a facilitated assessment of the strengths, weaknesses, opportunities, and concerns (SWOC) of current equity work, which resulted in an equity training plan. CFPS is committed to offering additional training and learning opportunities that will cover more equity topics.

Family interviews. Conducting interviews with the surviving members of a young person's family should also be prioritized as a way to center equity and justice in child death review. Confidential family interviews provide powerful personal stories and key details of the family and young person's experiences. Personal experiences have profound impacts on outcomes for infants, children, and youth, and public health professionals will only learn about them

through listening to family's stories. Family interviews can shed light on the social determinants of health, including experiences of unstable housing, poverty, racism, and discrimination. These insights are typically not available from any other source and provide critical information about the conditions affecting health within a given community. Trusting and valuing the stories that family members share allows child death review teams to better understand the context of the deaths and the resulting fatality review data. Family members' ideas for prevention can also lead to more equitable and culturally relevant recommendations. Interviews also provide an opportunity to link surviving family members to needed resources, provide bereavement support, and give them a compassionate professional to listen to the story of their child's death. With compassion and persistence, teams will hear stories of loss and maximize the impact of those stories by using them to craft effective, relevant interventions to increase the health and safety of their communities.[59]

To assess feasibility and current best practices in family interviews for the public health child death review process, CFPS spoke with professionals from cities and states outside of Colorado who use family interviews. Colleagues in other jurisdictions consistently highlighted the value of including the first-hand experience of families to inform the review and recommendation process, which helped clarify what this practice might look like in Colorado. CFPS identified that the Denver local team, coordinated by the Office of the Medical Examiner, was uniquely positioned to pilot family interviews. Including family advocates at coroner's and medical examiner's offices is an innovative practice, and the program in Denver is the first and only one in the state.[60] Because the Denver coordinator already interacts with families following the death of a loved one to offer resources, starting in summer 2022 they will begin offering families who have lost children the opportunity to provide additional information that will be included in the child death review process. Additionally, the El Paso County Coroner's Office now includes a question about experiences of discrimination in the standard questions that families are asked following the death of a child. Lessons learned from local partners and partners in other jurisdictions will inform CFPS' ability to expand the use of direct information from families and family interviews to additional counties.

In April 2020, NCFRP revised the CRS to include a new "Life Stressors" section. The goal of this section is to better understand the environmental stressors impacting a child, their family, or their community. Life stressors include racism, discrimination, poverty, food insecurity, and housing instability. Conducting family interviews and including community representatives during the child death review process will improve the knowledge and understanding of these social and economic stressors that affect families. In FY 2020-21, the CFPS state support team began developing guidance for teams to use when discussing the Life Stressors section, as well as an Equity Toolkit to assist local team coordinators with incorporating equity throughout the entire case review process. In FY 2021-22, the guidance document and toolkit will be finalized and disseminated.

CONCLUSION

Over the past eight years, the CFPS developed 48 child fatality prevention recommendations and made significant progress toward successfully implementing those recommendations using and developing statewide partnerships and resources. This report reflects the culmination of the collective expertise of system partners across Colorado. The structure of CFPS ensures coordination at the state and local levels and provides an opportunity to advance prevention strategies and improve systems. Changes in policy are effective prevention strategies for many types of child deaths. By supporting and adopting the recommendations outlined in this report, policymakers can save lives and make Colorado families more resilient to stresses caused by major life events like the COVID-19 pandemic.

Additionally, all Coloradans can play a role in increasing public support for policies supportive of children and families, especially policymakers. A focus on collective responsibility for the well-being and health of young people and their families will help shift the norm that places responsibility for children solely on parents and caregivers to a norm that considers caring for and protecting children as a shared, community responsibility.

Safeguarding the health and well-being of Colorado's infants, children, youth, and families is an increasing concern given the ongoing impacts of the COVID-19 pandemic. With Colorado families facing long-lasting social, psychological, and economic impacts of the pandemic, implementing policies that increase access to concrete supports for young people and their families like behavioral health is vitally important.

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